

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE



Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are FOUR (4) signatures on this page 4 to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: LAST FIRST MIDDLE INITIAL
Student Address: STREET CITY ZIP
Sex: M F Age: Date of Birth: Place of Birth (City/State):
School: Circle Grade: 6 7 8 9 10 11 12
Parent/Guardian Name:
Phone (home): (work): (cell):
Parent/Guardian Name:
Phone (home): (work): (cell):
Email Address: Parent/Guardian/18-Year-Old:

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume; and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

1 Signature of STUDENT: Date:

2 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date:

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: YES NO

If YES, Family Insurance Co: Insurance ID #:

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

3 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date:

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, an 18-year-old, or the parent or guardian of, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

4 Signature of PARENT or GUARDIAN or 18-YEAR-OLD: Date:

MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old



Student Name: _____ Date of Birth: _____
 Doctor: _____ Doctor's Phone: _____ Date of Exam: _____

- GENERAL QUESTIONS		Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?			
Do you have any ongoing medical conditions? If so, please identify below:			
<input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other:			
Have you ever spent the night in the hospital or have you ever had surgery?			
Do you have any concerns that you would like to discuss with a doctor?			
- HEART HEALTH QUESTIONS ABOUT YOU		Y	N
Have you ever passed out or nearly passed out DURING or AFTER exercise?			
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			
Has a doctor ever told you that you have any heart problems? Check all that apply:			
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other:			
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)			
Do you get lightheaded or feel more short of breath than expected during exercise?			
Do you have a history of seizure disorder or had an unexplained seizure? Fainting?			
Do you get more tired or short of breath more quickly than your friends during exercise?			
- HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Y	N
Has anyone in your family had a pacemaker or implanted defibrillator before age 35?			
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic, right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
- BONE AND JOINT QUESTIONS		Y	N
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?			
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?			
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?			
Do you regularly use a brace, orthotics or other assistive device?			
Do you have a bone, muscle or joint injury that bothers you?			
Do any of your joints become painful, swollen, feel warm or look red?			
Do you have any history of juvenile arthritis or connective tissue disease?			
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?			

- MEDICAL QUESTIONS		Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?			
Have you ever used an inhaler or taken asthma medicine?			
Is there anyone in your family who has asthma?			
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?			
Do you have groin pain or a painful bulge or hernia in the groin area?			
Have you had infectious mononucleosis (mono) within the last month?			
Do you have any rashes, pressure sores or other skin problems?			
Have you had a herpes or MRSA skin infection?			
Do you have headaches or get frequent muscle cramps when exercising?			
Have you ever become ill while exercising in the heat?			
Do you or someone in your family have sickle cell trait or disease?			
Have you had any problems with your eyes or vision or any eye injuries?			
Do you wear glasses or contact lenses?			
Do you wear protective eyewear such as goggles or a face shield?			
Immunization History: Are you missing any recommended vaccines?			
Do you have any allergies?			
Have you ever had a head injury or concussion?			
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?			
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?			
Have you ever had an eating disorder?			
Do you worry about your weight?			
Are you trying to or has anyone recommended that you gain or lose weight?			
Are you on a special diet or do you avoid certain types of foods?			
- FEMALES ONLY (Optional)		Y	N
Have you ever had a menstrual period?			
If "YES", When was your most recent menstrual period?			
How old were you when you had your first menstrual period?			
How many periods have you had in the last 12 months?			
CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR			

Please explain any "YES" answers: _____

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: _____ Weight: _____ Male Female BP: _____ / _____ Pulse: _____ Vision: R 20/ _____ L 20/ _____ Corrected: Y N

MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk		

RECOMMENDATIONS: _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities except: _____

EXAMINER → Name of Examiner (print/type): _____ Date: _____
 Signature of Examiner: _____ (Check One): MD DO PA NP
All Physicals MUST be dated on or after January 1st of current season. The doctor's business stamp must be affixed along with signature & date are required.
 ----- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -----

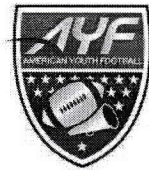
EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (____) _____
 IN EMERGENCY (1): _____ Home #: (____) _____ Cell #: (____) _____
 IN EMERGENCY (2): _____ Home #: (____) _____ Cell #: (____) _____
 Drug Reactions: _____ Current Medications: _____
 Allergies: _____



AMERICAN YOUTH FOOTBALL

Medical Clearance Form



ASSOCIATION NAME - West Seven Rams

Medical Clearance Form - Must be dated after January 1st of the Current Season

I, as evidenced by my name and signature below, do certify that I am a State Licensed Medical Examiner in the state of Michigan and am qualified in determining that:

(Childs Name:) _____ is physically fit and I have found no medical or observable conditions which would contra-indicate his/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities.

I am therefore clearing this individual for athletic participation.

Please Print - or - Use Office Stamp Here:

<p>Signature: _____</p> <p>Date: / /</p> <p>(Must be dated after January 1st, of the Current Season)</p> <p>_____</p>	<p>Print Name Clearly: _____</p> <p>Office Address: _____</p>
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PLEASE NOTE: If this Medical Clearance is voided by injury, accident, or illness, it will be the responsibility of the Parent/Legal Guardian to notify the participants Coach and League Officials. It will also be the responsibility of the Parent / Legal Guardian to obtain WRITTEN permission from his/her State Licensed Medical Examiner to resume participation. A "Doctors Resume Participation Medical Clearance Form" is available from the league or you may have the doctor supply his/her own WRITTEN Clearance as long as it is on the doctor's official stationary and includes the following statement:

"(Participants Name) is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation.

This statement must be supplied by the physician attending to the injury, accident, or illness.

This form can be modified or substituted ONLY to comply with local and/or state laws or due to medical practitioner regulations.

NOTE: This form as with any and all forms used by your Association should be reviewed by your local counsel for compliance with any state or local statutes. This form should be kept on file for a minimum of 7 years, longer in the event of an injury. Please confer with your local attorney for advice as to the appropriate maintenance and storage term for this and all such forms.