## PART 1: Information (to be filled out by parent or guardian ONLY)

Name: ____________________ Grade: ______ School: ________________ Sports: __________
Sex: M / F Age: _______ Date of Birth: ______________ Social Security Number: ____-___-_____
Address:________________________________ City:_______________ Zip: ______________
Home Phone: _____________________ Parent's Name: _______________________
Parent's Employer: _________________ Work Phone: _____________________
Insurance Company: ___________________ Policy Number: _______________________
Family Doctor: _____________________

## PART 2: Medical History (to be filled out by parent or guardian)

1. Have a medical problem or injury since his/her last evaluation........ Yes No
   Ever not been allowed to participate in sports for a medical reason........ Yes No
2. Ever been hospitalized........ Yes No
   Ever had surgery........ Yes No
   Have any missing organs (eye, kidney, testicle, etc)........ Yes No
3. Presently take any medication........ Yes No
4. Have any allergies to medicine or insect bites........ Yes No
5. Passed out during or after exercise........ Yes No
   Been dizzy or passed out during or after exercise........ Yes No
   Have chest pain during or after exercise........ Yes No
   Tire more quickly than his/her friends during exercise........ Yes No
   Have high blood pressure........ Yes No
   Been told he/she has heart murmurs........ Yes No
   Have racing of the heart or skipped heartbeat........ Yes No
   Have a family member that died of heart problems or sudden death before AGE 50........ Yes No
6. Have any skin problems........ Yes No
7. Ever had a head or neck injury........ Yes No
   Ever been knocked out or unconscious........ Yes No
   Ever had a seizure........ Yes No
   Ever had a stinger, burner, or pinched nerve........ Yes No
8. Ever had heat cramps........ Yes No
   Ever been dizzy or passed out in the heat........ Yes No
9. Have trouble with breathing or coughing during or after activity........ Yes No
10. Use any special equipment (pads, braces, neck rolls, eye guards, kidney bell, etc)........ Yes No
11. Have any problems with vision........ Yes No
    Wear glasses or contacts........ Yes No
12. Ever sprained/strained, dislocated, fractured, or had repeated swelling of any bones or joints........ Yes No
13. Have any medical problems listed below ( please check)........ Yes No

___ High blood pressure ______ Rheumatic Fever _____ Diabetes
___ Hepatitis ______ Mononucleosis _____ Abnormal bleeding
___ Tuberculosis ______ Asthma _____ Sickle cell disease/trait
____ Other (list) ________________________________________

14. List dates for last: Tetanus Shot ______________ Measles immunization ______________
15. Female athletes list dates for : First menstrual period ________________ Last menstrual period __________
    Longest time between periods last year ______________________

**Please explain all "yes" answers above:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**This information on this form is current and correct to the best of my knowledge........ Yes No**
**I give my permission for my child to be examined for school related activities........ Yes No**
**If, in the judgement of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent, and authorize for such care as may be deemed necessary........ Yes No**
**I recognize the evaluation of my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work or cardiac testing will be performed........ Yes No**
**I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately........ Yes No**

Signature of Parent/Guardian ______________________________ Date ______________

Signature of Studente Athlete ______________________________ Date ______________

# PHYSICAL EXAMINATION

**(To be filled out by the DOCTOR)**

| COMPLETE / LIMITED | HEIGHT | WEIGHT | BP | | PULSE |
|---|---|---|---|---|---|
| | **SYSTEM** | **NORMAL** | **ABNORMAL** | **INITIALS** | **COMMENT** |
| LIMITED | Heart | | | | |
| LIMITED | Lung | | | | |
| LIMITED | Other | | | | |
| COMPLETE | Abdominal | | | | |
| COMPLETE | Genitalia | | | | |
| COMPLETE | Neck | | | | |
| COMPLETE | Shoulder | | | | |
| COMPLETE | Elbow | | | | |
| COMPLETE | Wrist | | | | |
| COMPLETE | Hand | | | | |
| COMPLETE | Back | | | | |
| COMPLETE | Knee | | | | |
| COMPLETE | Ankle | | | | |
| COMPLETE | Foot | | | | |
| COMPLETE | Eye | Right 20/ | Left 20/ | **Corrected** | **Yes / No** |

**CLEARANCE:**

_________ A. Cleared

_________ B. Cleared after further evaluation/treatment

_________ C. Not Cleared for: ______ Collision ______ Contact ____Non-contact

**Recommendations:**

_______________________________________________

_______________________________________________

**Name of MD:** ______________________ **Date:** ______________

**Address:** ______________________ **Telephone:** ______________

**Signature of MD:** ______________________

KING'S DAUGHTERS
THERAPY CENTER

# Student-Athlete Authorization and Consent Form for Disclosure of Protected Health Information

I hereby authorize the King's Daughters Medical Center athletic trainers and other health care personnel to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at ______________________________ School.

I further understand that this protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators.

PARENT:
I, ______________________ (print), parent and/or guardian of ______________________, student-athlete, understand that my child's protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without either parent/legal guardian authorization under HIPAA. This authorization/consent expires one year from the date it is signed.

ADULT ATHLETIC STUDENT:
I, ______________________ (print), student-athlete, understand that my protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without my authorization under HIPAA. This authorization/consent expires one year from the date it is signed.

MEDICAL CONSENT STATEMENT:
I hereby grant permission to KDMC athletic trainers to serve as primary caretakers and to render emergency care, first aid, preventive, and rehabilitative treatment deemed reasonably necessary to protect my health and well-being.

---

## SIGNATURE FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS

______________________________
**Print Student-Athlete's Name**

______________________________ ______________________
**Signature Parent/Guardian** **Date / Time**

______________________________ ______________________
**Signature Adult Student Athlete** **Date / Time**

Date Created: 11/08/2017 Date Reviewed / Approved: 01/08/2018