STUDENT AND PARENT CONSENT FORM

OTSEGO ATHLETIC DEPARTMENT

This form must be provided and on file at the Athletic Office, and updated each school year.

***PLEASE PRINT NAME OF STUDENT ATHLETE**

FIRST _____ **MIDDLE** _____ **LAST** _____

DATE OF BIRTH _____ **City/State Birth** _____

Student-Athlete participation

This application to participate in athletics at Otsego High School is voluntary on my part and is made with the understanding that I will abide by all the participation and eligibility rules set up by the M.H.S.A.A. and Otsego High School.

Student Signature _____

PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above high school student to engage in interscholastic athletics at Otsego High School in M.H.S.A.A. approved sports during the current school year and to accompany the team as a member on scheduled out of town trips. I understand that my son/daughter will be expected to adhere firmly to all established athletic policies. I have read both the Otsego Athletic Handbook (www.otsegops.org) and the M.H.S.A.A. rules of Eligibility (www.mhsaa.com) .

_____ _____

Date **Signature of Parent or Guardian**

PARENT E-MAIL CONTACT_____**CHECK IF NONE AVAILABLE**_____

****

FAMILY/DEPENDENT INSURANCE COMPANY_____ **Primary Health Coverage for this student**

(CHECK IF NONE AVAILABLE FOR THIS STUDENT AT THIS TIME _____

MEDICAL EMERGENCY INFORMATION AND CONSENT TO MEDICAL TREATMENT

Student's Name _____ **Grade** _____

IN EMERGENCY:

PARENT CONTACT PHONE: _____

ALTERNATE CONTACT #1 NAME: _____ **PHONE:** _____

ALTERNATE CONTACT #2 NAME: _____ **PHONE:** _____

HOSPITAL CHOICE _____

- **Some insurance companies require In-Network Service Providers, If Not applicable, write "closest".**

I _____**recognize that as a result of athletic participation medical treatment on**

Parent/Guardian Name authorizing

Emergency basis may become necessary for my child 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.

_____ _____

Date **Signature of Parent or Guardian**

PHYSICAL EXAMINATION CLEARANCE FORM

This form must be on file in the school before practicing with any athletic team

Student Name:_____ Birth Date: _____ Age:____ Gender: M / F

Address:_____

Home Telephone: _____ - _____ - _____

School:_____ Grade: ____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check One Box)

☐ **(1) Participate in all school interscholastic activities without restrictions.**

☐ **(2) Not cleared for:** ☐ **All Sports** ☐ **Specific Sports** _____

Cross out specific sports below not cleared for participation.

Sport classification based on contact:

Collision Contact Sports	Limited Contact Sports	Non-contact Sports
Basketball Boys Lacrosse Diving Football Ice Hockey Soccer Wrestling	Baseball Competitive Cheer Girls Lacrosse Girls Gymnastics Alpine Skiing Girls Softball Track Field Events High Jump Pole Vault Girls Volleyball	Bowling Cross Country Golf Swimming Tennis Track Running Track Field Events Discus Shot Put

Sport classification based on intensity and strenuousness:

High Intensity High-to-Moderate Dynamic High-to-Moderate Static	High Intensity High-to-Moderate Dynamic Low Static	High Intensity Low Dynamic High-to-Moderate Static	Low Intensity Low Dynamic Low Static
Alpine Skiing Cross Country Football Ice Hockey Track Events - Distance Track Events - Sprint Wrestling	Baseball Lacrosse (Boys and Girls) Soccer Girls Softball Swimming Tennis Girls Volleyball	Girls Competitive Cheer Diving Field Events Girls Gymnastics	Bowling Golf

☐ **(3) Requires further evaluation before a final recommendation can be made.**
Additional recommendations for the school or parents**:** _____
_____

I have examined the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Examiner Signature:_____ Date of Exam: _____

Print Examiner Name: _____

Address: _____

Office Telephone: _____ - _____ - _____ _____

COPY BOTH SIDES OF THIS SHEET FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE FORM IN THE STUDENTS MEDICAL RECORD

---------- < DETACH HERE IF NEEDED TO ACCOMPANY STUDENT ATHLETE > ----------

EMERGENCY INFORMATION FOR: _____ Grade: ____

Allergies – Drug Reactions – Current Medications: _____

Other Special Medical Information: _____

Emergency Contact: _____ Relationship: _____

Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____

Personal Physician _____ Office Telephone _____ - _____ - _____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

_____

Do you have any allergies? Yes ☐ No ☐ If yes, please identify specific allergy below.

☐ Medicines ☐ Pollen ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4, Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESITONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you ever received tetanus-diphtheria-pertussis (Tdap) vaccine?		
52. Are you missing any recommended vaccines (such as Tdap, MCV4, HPV, Varicella, MMR, Flu, etc.)?		
53. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain " yes" answers here

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

(The provider should keep this form in the chart)

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - During the past 30 days, did you use chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seatbelt, use a helmet and use condoms?
2. **Please review questions on cardiovascular symptoms and family history (questions 5-16) with parent and/or student athlete**

EXAMINATION			
Height	Weight	☐ Male	☐ Female
BP / (/)	Pulse	Vision R 20/	L 20/ Corrected Yes or No
MEDICAL		**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) [b]			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [c]			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Immunizations:
Has the student-athlete received all ACIP-recommended vaccines? ☐ Yes ☐ No

Check the Michigan Care Improvement Registry (MCIR) for vaccination status: www.mcir.org