

**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	MEDICAL 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?							
HEART HEALTH QUESTIONS ABOUT YOU		Y	N	Do you have groin pain or a painful bulge or hernia in the groin area?			
Have you ever passed out or nearly passed out DURING or AFTER exercise?							
Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?							
Does your heart ever race 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?							
Do you get more tired or short of breath more quickly than your friends during exercise?							
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Y	N	Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?			
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?							
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?							
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?							
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?							
BONE AND JOINT QUESTIONS		Y	N	Do you have infectious mononucleosis (mono) within the last month?			
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)?							
				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?			
				Do you have any concerns that you would like to discuss with a doctor?			
				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?			
				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							

**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, linea 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 NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY  
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

**EXAMINER**

Name of Examiner (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_ (Check One): ☐ MD ☐ DO ☐ PA ☐ NP

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

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

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

N EMERGENCY (1): \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

N EMERGENCY (2): \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Drug Reactions: \_\_\_\_\_ Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_





# 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

Gender: ☐ M ☐ F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth (City/State): \_\_\_\_\_

School: \_\_\_\_\_ Circle Grade: 6 7 8 9 10 11 12

Father/Guardian Name: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ (cell): \_\_\_\_\_

Mother/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

\_\_\_\_\_, 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: \_\_\_\_\_



## Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

### UNDERSTANDING CONCUSSION

#### Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

#### WHAT IS A CONCUSSION?

A **concussion is a type of traumatic brain injury** that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

#### IF YOU SUSPECT A CONCUSSION:

- 1. SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
- 2. KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a health care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.
- 3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

#### SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

#### CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

#### HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to [www.cdc.gov/concussion](http://www.cdc.gov/concussion).

**Parents and Students Must Sign and Return the Educational Material Acknowledgement Form**

# CONCUSSION AWARENESS

## EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by \_\_\_\_\_

\_\_\_\_\_  
Sponsoring Organization

\_\_\_\_\_  
Participant Name Printed

\_\_\_\_\_  
Parent or Guardian Name Printed

\_\_\_\_\_  
Participant Name Signature

\_\_\_\_\_  
Parent or Guardian Name Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.