



# ATHLETE EMERGENCY INFORMATION

By its nature, participation in interscholastic athletics includes risk of injury. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants can, and have the responsibility to, help reduce the chance of injury. Participants must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

## CONTACT INFORMATION

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

1. Please circle one: Father Mother Guardian Step-parent Other: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Please number, in order of preference (#1 being your first preference), the phone numbers to be called in the event of an emergency

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

Parent/Guardian Email: \_\_\_\_\_ (other) \_\_\_\_\_

2. Please circle one: Father Mother Guardian Step-parent Other: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

## EMERGENCY INFORMATION

Family Doctor: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_ (other) \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Choice of Hospital: \_\_\_\_\_

Hospital Phone: \_\_\_\_\_

Hospital Address: \_\_\_\_\_

"I hereby give my consent for the above named student,

1. to accompany any school team of which they are a member on its local or out-of town trips;
2. to receive, through a medical doctor of the school's choice, emergency medical care that may become reasonably necessary in the course of such athletic activities or such travel. I further agree to not hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the proper course of such athletic activities or travel."

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Brownell Talbot**  
**400 N. Happy Hollow Blvd.**  
**Omaha, NE 68132**  
**402.556.3772**

**Jeff Rohrig, Activities Director**  
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# PREPARTICIPATION PHYSICAL EVALUATION

## HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_  
 \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).  
 \_\_\_\_\_  
 \_\_\_\_\_

### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. 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)?		
12. 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)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



# ■ PREPARTICIPATION PHYSICAL EVALUATION

## ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	<b>Yes</b>	<b>No</b>
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

**Explain "Yes" answers here.**

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**Please indicate whether you have ever had any of the following conditions:**

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

**Explain "Yes" answers here.**

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

**Signature of athlete:** \_\_\_\_\_

**Signature of parent or guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### PHYSICIAN REMINDERS

- 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, e-cigarettes, chewing tobacco, snuff, or dip?
  - 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-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional - Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

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**I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.**

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_

\_\_\_\_\_

- Medically eligible for certain sports

\_\_\_\_\_

\_\_\_\_\_

- Not medically eligible pending further evaluation

- Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Signature of health care professional:** \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

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

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ATHLETIC CODE OF CONDUCT

## STUDENT PARENT AGREEMENT

Before participation on any team is permitted, all students who wish to participate and their parent(s)/guardian(s) shall sign the Athletic Policy and Guidelines Agreement indicating that they have reviewed and understand all the policies and guidelines of the Athletic Policy and Guidelines as found in the Brownell Talbot Student/Parent Handbook. The parent/guardian and the student-athlete must sign this agreement.

Failure of a student to comply with the Athletic Code of Conduct will result in disciplinary action and possible dismissal from the team. Coaches will communicate to the student and parents any disciplinary action resulting in the denial of a student-athlete's participation and the reasons for that action.

## SIGNATURE OF AGREEMENT FORM

Please return only this page to the front office with the other athletic forms. Keep the policy and guidelines for a reference. This form is in effect for the entire school year.

Athlete's Name  
(Please Print)

I understand and agree to abide by all the provisions of the Brownell Talbot Athletic Code.

Date \_\_\_\_\_ Athlete's Signature \_\_\_\_\_

I understand and agree to abide by all the provisions of the Brownell Talbot Athletic Code.

Date \_\_\_\_\_ Parent's Signature \_\_\_\_\_

**Please return prior to the first day of practice.**

**Brownell Talbot**  
**400 N. Happy Hollow Blvd.**  
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**402.556.3772**

6/23/2020

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