



Department of Health and Human Services Physical Examination Report

Name of School (if desired) _____

The school board shall require evidence of (a) a physical examination by a physician, a physician assistant, or an advanced practice registered nurse within six months prior to the entrance of a child into the beginner grade and the seventh grade or, in the case of a transfer from out of state, to any other grade of the local school; and (b) for school year 2006-07 and each school year thereafter, a visual evaluation by a physician, physician assistant, an advanced practice registered nurse, or an optometrist within six months prior to the entrance of a child into the beginner grade or, in the case of a transfer from out of state, to any other grade of the local school, which consists of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity, except that no such physical examination or visual evaluation shall be required of any child whose parent or guardian objects in writing. The cost of such physical examination and visual evaluation shall be borne by the parent or guardian of each child who is examined. Nebraska Revised Statutes 79-214 (excerpt).

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for physical examination in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

By signing below, the parent/guardian of _____ consents for the

Name of Student

release of the health and medical information contained herein to be released to _____

Name of School

Signature

Printed Name/Relationship to Student

Date

Student Name	School	Grade
Student Address	Zip	Age
Physician Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight	Medical	Normal	Abnormal Findings
Blood Pressure	Pulse			
Urinalysis		Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin/Hct		Eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>
Audiometric Screening Report		Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
		Heart (note murmur if present)	<input type="checkbox"/>	<input type="checkbox"/>
		Pulses (inc. Femoral)	<input type="checkbox"/>	<input type="checkbox"/>
		Lungs	<input type="checkbox"/>	<input type="checkbox"/>
		Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
		Skin	<input type="checkbox"/>	<input type="checkbox"/>
		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
		Neck	<input type="checkbox"/>	<input type="checkbox"/>
		Spine	<input type="checkbox"/>	<input type="checkbox"/>
		Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>
		Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>
		Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>
		Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>
		Knee	<input type="checkbox"/>	<input type="checkbox"/>
		Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>
		Foot	<input type="checkbox"/>	<input type="checkbox"/>
		Evidence of Scoliosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		Evidence of Hernia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		Stigmata of Marfan's Syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Immunizations given during today's visit:
 DTP Td Polio MMR Hib Hep B Varicella
 Other (list) _____
(Please attach copy of immunization record on file.)

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 feet: Right 20/_____ Left 20/_____ with/without glasses			
16 inches: Right 20/_____ Left 20/_____ with/without glasses			

Required medication on a daily or episodic routine:

Please check classification

- Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related activities without undue risk or injury.
- Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Reexamine each year.
- Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. These students should be reexamined for possible reclassification at the end of the exemption period.

Please check certification

- Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic athletics. Activities student should **not** participate in: _____

Significant findings/chronic health concerns

Your signature below indicates completion of physical exam and review of health history.

Date _____ Signed _____
Examining Physician (Signature Required)

Clinic/Practice Name (please print) _____ Physician Phone _____

Physician Address _____

Return to School Health Office

Please enter School Name here

Health History (Seventh Grade through High School)



Student Name _____

Date of Birth _____

Sex: M F

Parent/Guardian Name: _____

Address: _____

Parent/Guardian Telephone: _____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's health care provider. Please contact the school nurse if you have questions. Return the completed form to the school health office.

Please check the third box for the questions you don't know the answer to. Explain "yes" answers below.

	Y	N	?
1. Has there been a medical illness or injury since the last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the student ever been hospitalized overnight? Has the student ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the student currently taking any prescription or non prescription (over-the-counter) medications or pills or using an inhaler? Any supplements or vitamins to help weight gain/weight loss or improve athletic performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the student have any allergies (for example- pollen, medicine, food or stinging insects)? Has the student ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the student ever passed out during exercise? Has the student ever been dizzy during or after exercise? Has the student ever had chest pain during or after exercise? Does the student get tired more quickly than friends do during exercise? Has the student ever had racing of their heart or skipped heartbeats? Has the student ever had high blood pressure or cholesterol? Has the student ever been told he/she has a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Has any family member or relative been diagnosed with cardiomyopathy (thick heart), long QT Syndrome or Marfan Syndrome? Has the student had a severe viral infection (for example- myocarditis or mononucleosis) within the past month? Has a physician ever denied or restricted participation on sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the student have any current skin problems (for example- itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the student ever had a head injury or concussion? Has the student ever been knocked out, become unconscious or lost their memory? Has the student ever had a seizure? Does the student have frequent or severe headaches? Does the student ever have numbness or tingling in arms, hands, legs, or feet? Has the student ever has a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Y	N	?
8. Has the student ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the student cough, wheeze or have trouble breathing during or after activity? Does the student have asthma? Does the student have season allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the student use any special protective or corrective equipment or devices that aren't usually used for their sport or position (for example- knee brace, special neck roll, foot orthotics, retainer on their teeth or hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the student had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the student ever had a sprain, strain, or swelling after injury? Has the student broken or fractured any bones or dislocated any joints? Has the student had any other problems with pain or swelling in muscles, tendons, bones or joints? Check all that apply. <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hip <input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the student want to weigh more or less than they do at the present time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Does the student complain of feeling stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY

15. When was the first menstrual period? _____

When was the most recent menstrual period? _____

How much time usually passes between the start of one period and the start of the next? _____

How many periods has the student had in the past year? _____

What was the longest time between periods in the past year? _____

Explain your answers here:

Completed by _____

Relationship to student _____

Date _____



NSAA Athletic and Activities Student and Parent Consent Form

School Year:
Member High School:
Name of Student:
Date of Birth: Place of Birth:
Name of Parent(s), Guardian(s), or Person(s) in Charge:
Relationship to Student:
Address(es) of Student and Parent(s)/Guardian(s)/or Person(s) in Charge**:

Note: If Student and all Parents/Guardians do not live in the same household, please include all addresses and inform the Member School as this may impact eligibility.

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege and understand and agree that (a) by this Consent Form the NSAA has provided notice of the existence of potential dangers associated with athletic and activity participation; (b) participation in any activity may involve injury or illness of some type, including exposure to communicable diseases, and even catastrophic injury, paralyzation, and death; and (c) even the best supervision, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(2) Consent and agree to participation of the Student in NSAA activities subject to (a) all NSAA Bylaws and rules interpretations, including limitations on transfers and limitations on the use of the Student's name, image, and likeness when wearing school uniforms or engaging in commercial activity tied to the Student's participation in NSAA activities; and (b) the athletic and activities rules of the Member School;

(3) Consent and agree to the disclosure by the Member School to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student contained in the Member School's directory information or other similar policies, and any other records or documentation needed to determine the Student's eligibility and compliance necessary to participate in NSAA activities;

(4) Understand that (a) prior to athletic participation, a pre-participation release form signed by a health care professional must be signed and submitted to the Member School; and (b) for purposes of determining fitness to participate, injury, injury status, or emergency response, Parents may be asked to consent to the disclosure of confidential medical records or information. Records and information shared for this purpose will not be redisclosed to any entities outside of the health care provider(s), Member School, or NSAA;

(5) Consent and agree (a) to authorize licensed or trained individuals, including certified sports injury personnel, to evaluate and treat any injury or illness that occurs during the Student's participation in NSAA activities. This includes all reasonable and necessary care, treatment, and rehabilitation for these injuries that is made available by the Member school and/or the NSAA, including transportation of the Student to a medical facility if necessary; and (b) that Parents are obligated to pay for professional medical and/or related services; the NSAA and the Member School shall not be liable for payment of such services even if made available by the Member School or NSAA.

(6) Understand that the Student or Student's likeness being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests and that any such recording may be used for broadcast, sale, or display.

We, Parent(s) and Student, acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities, and agree that Student may participate in NSAA activities.

Student Printed Name

Student Signature

Date of Signature

Parent(s) Printed Name(s)

Parent Signature(s)

Date of Signature(s)

ATHLETIC INSURANCE COVERAGE
Conestoga Public Schools

Student-Athlete Name _____

Athletes and Parents,

Conestoga Public Schools will be offering athletic insurance coverage to participants. The purpose is to assist in the cost of treatment of accidental injury. The insurance company plan will be made available to those who wish to participate. The cost of the athletic insurance will be borne totally by the parent.

Whether you wish to participate or not, please complete this form. **No athlete may participate as a member of any team until this form has been completed and submitted to the school through the activities director or coach/sponsor.**

CHECK THE STATEMENTS WHICH APPLY:

_____ I will participate in the Athletic Benefit Injury Plan offered by Conestoga Public Schools and have completed the required application and paid the premium cost.

_____ I will not participate in the Athletic Benefit Injury Plan and will assume all expenses for accidental injury. My son/daughter is covered by another policy.

_____ I choose not to enroll my daughter/son in an insurance program and I understand I will be responsible for all expenses for treatment of any accident or injury.

Parent/Guardian Signature

Date

AUTHORIZATION AND ACKNOWLEDGEMENT

WARNING: SERIOUS CATASTROPHIC AND PERHAPS FATAL INJURY MAY RESULT FROM ATHLETIC PARTICIPATION

Many forms of athletic competition result in violent physical contact among players, the use of equipment that may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision will eliminate these risks. Students have suffered accidents resulting in death, paraplegia, quadriplegia, and other very serious permanent physical impairment while playing sports. By granting permission for your student to participate in athletic competition, you, the parent or guardian, acknowledge that such risk exists. Students will be instructed in proper techniques to be used in athletic competition and in the proper utilization of all equipment worn or used in practice and competition. Students must adhere to that instruction and utilization and must refrain from improper uses and techniques.

I understand the statement above and I understand that by allowing my student to participate in athletic events, I assume the risk that he/she may be injured, perhaps severely.

Signature of Parent

Printed Name of Parent

Date

ACKNOWLEDGEMENT OF CONDUCT CODE

I understand that as a student representing the school district in activities, I am obligated to comply with the athletic handbook, including the code of conduct. This means that I may not possess, use, or be at parties in the presence of alcohol, illicit drugs, or controlled substances at any time during the calendar year unless I am accompanied by a parent. I understand that if I violate the code of conduct or other rules in this handbook, I may be suspended from participation in all co-curricular activities and/or school sponsored activities or events.

Signature of Student

Printed Name of Student

Date

I understand that my student is obligated by this handbook, including the statements above.

Signature of Parent

Printed Name of Parent

Date

****This form must be signed and returned before any student can participate in any activity****