Leavenworth High School
Sports Physical Packet
2019-20

All LHS fall sports will start August 19, 2019

An updated physical form
must be on file in order to participate.
HISTORY FORM (should be filled out by the student and parent/guardian prior to the physical examination)

Name
Sex
Age
Date of birth

Grade
School
Sport(s)

Home Address
Phone

Personal physician
Parent Email

Pre-Participation Physical Evaluation

Kansas State High School Activities Association • 601 SW Commerce Place • PO Box 495 • Topeka, KS 66601 • 785-273-5329

Explanation of questions:

Medicines and Allergies: List all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking:

☐ Medicines ____________________________________________________________________________
☐ Pollens ________________________________________________
☐ Food ________________________________________________________________________________
☐ Stinging Insects________________________

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

General Questions

Yes
No
1. Have you had a medical condition or injury since your last checkup or sports physical?
2. Has a doctor ever denied or restricted your participation in sports for any reason?
3. Do you have any ongoing medical conditions? If so, please identify below:
   □ Asthma
   □ Anemia
   □ Diabetes
   □ Infections
   □ Other:

4. Have you ever spent the night in the hospital?
5. Have you ever had surgery?

Heart Health Questions About You

Yes
No

6. Have you ever passed out or nearly passed out during or after exercise?
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
8. Does your heart ever race or skip beats (irregular beats) during exercise?
9. 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:

10. Has a doctor ever ordered a test for your heart? (For example, ECG/ekg, echocardiogram)

11. Do you get lightheaded or feel more short of breath than expected during exercise?
12. Have you ever had an unexplained seizure?
13. Do you get more tired or short of breath more quickly than your friends during exercise?

Heart Health Questions About Your Family

Yes
No

14. 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)?
15. 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?
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

Bone And Joint Questions

Yes
No

18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?
19. Have you ever had any broken or fractured bones or dislocated joints?
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
21. Have you ever had a stress fracture?
22. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
23. Do you regularly use a brace, orthotics, or other assistive device?
24. Do you have a bone, muscle, or joint injury that bothers you?
25. Do any of your joints become painful, swollen, feel warm, or look red?
26. Do you have any history of juvenile arthritis or connective tissue disease?

Medical Questions

Yes
No

27. Do you cough, wheeze, or have difficulty breathing during or after exercise?
28. Have you ever used an inhaler or taken asthma medicine?
29. Is there anyone in your family who has asthma?
30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
31. Do you have groin pain or a painful bulge or hernia in the groin area?
32. Have you had infectious mononucleosis (mono) within the last month?
33. Do you have any rashes, pressure sores, or other skin problems?
34. Have you had a herpes or MRSA skin infection?
35. Have you ever had a head injury or concussion?
36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
37. Do you have a history of seizure disorder?
38. Do you have headaches with exercise?
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling (Stinger/Burner/Pinched Nerve)?
40. Have you ever been unable to move your arms or legs after being hit or falling?
41. Have you ever become ill while exercising in the heat?
42. Do you get frequent muscle cramps when exercising?
43. Do you or someone in your family have sickle cell trait or disease?
44. Have you had any problems with your eyes or vision?
45. Have you had any eye injuries?
46. Do you wear glasses or contact lenses?
47. Do you wear protective eyewear, such as goggles or a face shield?
48. Do you worry about your weight?
49. Are you trying to or has anyone recommended that you gain or lose weight?
50. Are you on a special diet or do you avoid certain types of foods?
51. Have you ever had an eating disorder?
52. Do you have any concerns that you would like to discuss with a doctor?

Females Only

Yes
No

53. Have you ever had a menstrual period?
54. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)?
55. How old were you when you had your first menstrual period?
56. How many periods have you had in the last 12 months?

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

Medicines _________________________
Pollens _________________________
Food ________________________
Stinging Insects ____________________

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

When were you last released?___________________________________________
What is the longest you've been held out of sports or school? __________________

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 ________________

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Rev. 1/15
**PHYSICAL EXAMINATION FORM**

Name: ____________________________ Date of birth: ____________________________

Date of recent immunizations:  
- Td  
- Tdap  
- Hep B  
- Varicella  
- HPV  
- Meningococcal

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Have you ever felt sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried 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 supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt and use a helmet?

2. Consider reviewing questions on cardiovascular symptoms (questions 6-17).

<table>
<thead>
<tr>
<th>Examination</th>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>BP (corrected for height/age)</th>
<th>/</th>
<th>( )</th>
<th>Pulse</th>
</tr>
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<tbody>
<tr>
<td>Vision R 20/</td>
<td>L 20/</td>
<td>Corrected: Yes</td>
<td>No</td>
<td></td>
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**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
  - Gross Hearing

- Lymph nodes

- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- Pulses
  - Simultaneous temporal and radial pulses

- Lungs

- Abdomen

- Genitourinary (males only)**

- Skin
  - HSV, lesions suggestive of MRSA, tinea corporis

- Neurologic***

**MUSCULOSKELETAL**

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/ankle
- Foot/toes

- Functional
  - Duck-walk, single leg hop

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

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________

☐ Not cleared
  - Pending further evaluation
  - For any sports
  - For certain sports ____________________________

  *Reason ____________________________

Recommendations ____________________________

I have examined the above-named student and student history 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. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of healthcare provider (print/type): ____________________________ Date: ____________________________

Address __________________________________________ Phone ____________________________

Signature of healthcare provider ____________________________ Date: ____________________________


Rev. 1/15
ATTENTION PARENTS AND STUDENTS
KSHSAA ELIGIBILITY CHECK LIST

NOTE: Transfer Rule 18 states in part, a student is eligible transfer-wise if:

BEGINNING SEVENTH GRADER—A seventh grader, at the beginning of his or her seventh grade year, is eligible under the Transfer Rule at any school he or she may choose to attend. In addition, age and academic eligibility requirements must also be met.

BEGINNING NINTH GRADERS IN A THREE-YEAR JUNIOR HIGH SCHOOL—So that ninth graders of a three-year junior high are treated equally to ninth graders of a four-year senior high school, a student who has successfully completed the eighth grade of a two-year junior high/middle school, may transfer to the ninth grade of a three-year junior high school at the beginning of the school year and be eligible immediately under the Transfer Rule. Such a ninth grader must then as a tenth grader, attend the feeder senior high school of their school system. Should they attend a different school as a tenth grader, they would be ineligible for eighteen weeks.

ENTERING HIGH SCHOOL FOR THE FIRST TIME—A senior high school student is eligible under the Transfer Rule at any senior high school he or she may choose to attend when senior high is entered for the first time at the beginning of the school year. In addition, age and academic eligibility requirements must also be met.

For Middle/Junior High and Senior High School Students to Retain Eligibility

Schools may have stricter rules than those pertaining to the questions above or listed below. Contact the principal or coach on any matter of eligibility. A student to be eligible to participate in interscholastic activities must be certified by the school principal as meeting all eligibility standards.

All KSHSAA rules and regulations are published in the official KSHSAA Handbook which is distributed annually and is available at your school principal's office.

Below Are Brief Summaries Of Selected Rules. Please See Your Principal For Complete Information.

Rule 7 Physical Evaluation - Parental Consent—Students shall have passed the attached evaluation and have the written consent of their parents or legal guardian.

Rule 14 Bona Fide Student—Eligible students shall be a bona fide undergraduate member of his/her school in good standing.

Rule 15 Enrollment/Attendance—Students must be regularly enrolled and in attendance not later than Monday of the fourth week of the semester in which they participate.

Rule 16 Semester Requirements—A student shall not have more than two semesters of possible eligibility in grade seven and two semesters in grade eight. A student shall not have more than eight semesters of possible eligibility in grades nine through twelve, regardless of whether the ninth grade is included in junior high or in a senior high school.

NOTE: If a student does not participate or is ineligible due to transfer, scholarship, etc., the semester(s) during that period shall be counted toward the total number of semesters possible.

Rule 17 Age Requirements—Students are eligible if they are not 19 years of age (16, 15 or 14 for junior high or middle school student) on or before September 1 of the school year in which they compete.

Rule 19 Undue Influence—The use of undue influence by any person to secure or retain a student shall cause ineligibility. If tuition is charged or reduced, it shall meet the requirements of the KSHSAA.

Rules 20/21 Amateur and Awards Rules—Students are eligible if they have not competed under a false name or for money or merchandise of intrinsic value, and have observed all other provisions of the Amateur and Awards Rules.

Rule 22 Outside Competition—Students may not engage in outside competition in the same sport during a season in which they are representing their school.

NOTE: Consult the coach or principal before participating individually or on a team in any game, training session, contest, or tryout conducted by an outside organization.

Rule 25 Anti-Fraternity—Students are eligible if they are not members of any fraternity or other organization prohibited by law or by the rules of the KSHSAA.

Rule 26 Anti-Tryout and Private Instruction—Students are eligible if they have not participated in training sessions or tryouts held by colleges or other outside agencies or organizations in the same sport while a member of a school athletic team.

Rule 30 Seasons of Sport—Students are not eligible for more than four seasons in one sport in a four-year high school, three seasons in a three-year high school or two seasons in a two-year high school.
To be eligible for participation in interscholastic athletics/spirit groups, a student must have on file with the superintendent or principal, a signed statement by a physician, chiropractor, physician’s assistant who has been authorized to perform the examination by a Kansas licensed supervising physician or an advanced practice registered nurse who has been authorized to perform this examination by a Kansas licensed supervising physician, certifying the student has passed an adequate physical examination and is physically fit to participate (See KSHSAA Handbook, Rule 7). A complete history and physical examination must be performed annually before a student participates in KSHSAA interscholastic athletics/cheerleading. The annual history and the physical examination shall not be taken earlier than May 1 preceding the school year for which it is applicable. The KSHSAA recommends completion of this evaluation by athletes/cheerleaders at least one month prior to the first practice to allow time for correction of deficiencies and implementation of conditioning recommendations.

**Parent or Guardian Consent**

I do not know of any existing physical or any additional health reasons that would preclude participation in activities. I certify that the answers to the questions in the HISTORY part of the Preparticipation Physical Examination (PPE), are true and accurate. I approve participation in activities. I hereby authorize release to the KSHSAA, school nurse, certified athletic trainer, school administrators, coach and medical provider of information contained in this document. Upon written request, I may receive a copy of this document for my own personal health care records.

I acknowledge that there are risks of participating, including the possibility of catastrophic injury.

I hereby give my consent for the above student to compete in KSHSAA approved activities, and to accompany school representatives on school trips and receive emergency medical treatment when necessary. It is understood that neither the KSHSAA nor the school assumes any responsibility in case of accident. The undersigned agrees to be responsible for the safe return of all equipment issued by the school to the student.

The above named student and I have read the KSHSAA Eligibility Check List and how to retain eligibility information listed in this form.

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**For Middle/Junior High and Senior High School Students to Determine Eligibility When Enrolling**

If a negative response is given to any of the following questions, this enrollee should contact his/her administrator in charge of evaluating eligibility. This should be done before the student is allowed to attend his/her first class and prior to the first activity practice. If questions still exist, the school administrator should telephone the KSHSAA for a final determination of eligibility. (Schools shall process a Certificate of Transfer Form T-E on all transfer students.)

YES NO

1. □ □ Are you a bona fide student in good standing in school? (If there is a question, your principal will make that determination.)
2. □ □ Did you pass at least five new subjects (those not previously passed) last semester? (The KSHSAA has a minimum regulation which requires you to pass at least five subjects of unit weight in your last semester of attendance.)
3. □ □ Are you planning to enroll in at least five new subjects (those not previously passed) of unit weight this coming semester? (The KSHSAA has a minimum regulation which requires you to enroll and be in attendance in at least five subjects of unit weight.)
4. □ □ Did you attend this school or a feeder school in your district last semester? (If the answer is “no” to this question, please answer Sections a and b.)
   □ □ a. Do you reside with your parents?
   □ □ b. If you reside with your parents, have they made a permanent and bona fide move into your school’s attendance center?

The student/parent authorizes the school to release to the KSHSAA student records and other pertinent documents and information for the purpose of determining student eligibility. The student/parent also authorizes the school and the KSHSAA to publish the name and picture of student as a result of participating in or attending extra-curricular activities, school events and KSHSAA activities or events.

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Parent or Guardian’s Signature  Date

Student’s Signature  Date  Birth Date  Grade

Rev. 1/15
This form must be signed by all student athletes and parent/guardians before the student participates in any athletic or spirit practice or contest each school year.

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

### Symptoms may include one or more of the following:

- Headaches
- “Pressure in head”
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- “Don’t feel right”
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

### Signs observed by teammates, parents, and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

Adapted from the CDC and the 3rd International Conference in Sport

**What can happen if my child keeps on playing with a concussion or returns too soon?**

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete’s safety.
If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after sustaining a concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion. Remember it is better to miss one game than miss the whole season. **When in doubt, the athlete sits out!**

Cognitive Rest & Return to Learn

The first step to concussion recovery is cognitive rest. This is essential for the brain to heal. Activities that require concentration and attention such as trying to meet academic requirements, the use of electronic devices (computers, tablets, video games, texting, etc.), and exposure to loud noises may worsen symptoms and delay recovery. Students may need their academic workload modified while they are initially recovering from a concussion. Decreasing stress on the brain early on after a concussion may lessen symptoms and shorten the recovery time. This may involve staying home from school for a few days, followed by a lightened school schedule, gradually increasing to normal. Any academic modifications should be coordinated jointly between the student’s medical providers and school personnel. No consideration should be given to returning to physical activity until the student is fully integrated back into the classroom setting and is symptom free. Rarely, a student will be diagnosed with post-concussive syndrome and have symptoms that last weeks to months. In these cases, a student may be recommended to start a non-contact physical activity regimen, but this will only be done under the direct supervision of a healthcare provider.

Return to Practice and Competition

The Kansas School Sports Head Injury Prevention Act provides that if an athlete suffers, or is suspected of having suffered, a concussion or head injury during a competition or practice, the athlete must be immediately removed from the competition or practice and cannot return to practice or competition until a Health Care Professional has evaluated the athlete and provided a written authorization to return to practice and competition. The KSHSAA recommends that an athlete not return to practice or competition the same day the athlete suffers or is suspected of suffering a concussion. The KSHSAA also recommends that an athlete’s return to practice and competition should follow a graduated protocol under the supervision of the health care provider (MD or DO).

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/concussion/HeadsUp/youth.html
http://www.kansasconcussion.org/

For concussion information and educational resources collected by the KSHSAA, go to:
http://www.kshsaa.org/Public/General/ConcussionGuidelines.cfm

______________________________________________________________________       _____________________________       _____________
Student-athlete Name Printed               Student-athlete Signature        Date

______________________________________________________________________       ______________________________       _____________
Parent or Legal Guardian Printed            Parent or Legal Guardian Signature                Date

Revised 04/14
Code of Ethical Behavior Agreement  
for Participation in District Activities Program  
(Grades 9-12)

**Student Agreement**

If I am selected to represent the Leavenworth USD 453 Activities program, I will sincerely endeavor to contribute my best to the success of that program. I understand that I represent my family, school and community. I understand that my participation in the Leavenworth USD 453 Activities program is not a right, but a privilege. It is important that I present a positive image and serve as a role model for others. I acknowledge that I have received, reviewed, understand and agree to abide by the terms contained in Leavenworth USD 453’s Athletic/Activities Handbook. I, further acknowledge that I have received, read, understand, and agree to abide by the provisions of the “Code of Ethical Behavior” as described. I am also aware that if I do not live up to the requirements contained in the Athletic/Activities Handbook and the Code of Ethical Behavior, I must accept the consequences for my behavior, which may include dismissal from the activities programs (s).

I realize that if District or school policies are violated, the procedure and penalties of those policies will be enforced.

By signing this document, I, again, acknowledge that I have received, read and understand the policies contained in Leavenworth USD 453’s Athletic/Activities Handbook. I, further acknowledge that I have received, read, understand, and agree to abide by the provisions of the “Code of Ethical Behavior” as described. I am also aware that if I do not live up to the requirements contained in the Athletic/Activities Handbook and the Code of Ethical Behavior, I must accept the consequences for my behavior, which may include dismissal from the activities programs (s).

Date Signed: ____________  
Student Name (Please Print): _____________________________________________

Student’s Signature: __________________________________________________________________

Date Signed: ________________  
Grade Level: ________________

**Parental/Guardian Agreement**

By signing this document, I acknowledge that I have received, read and understand the policies contained in Leavenworth USD 453’s Athletic/Activities Handbook, and I understand the possible consequences if my child violates any of the policies contained therein.

Parent’s Name (Please Print): _____________________________________________

Parent’s Signature: __________________________________________________________________

Date Signed: ________________
Dear Parent/Guardian:

The athletic department is seeking your permission to have your son/daughter treated at a doctor’s office or hospital in the event that he or she is found in need of emergency treatment. If an emergency occurs, every effort will be made to contact you. However, if such contact cannot be made, this Emergency Medical Authorization may facilitate prompt treatment.

Student Name:_________________________________________________________________________

Address:____________________________________________________________________________

Birth Date:_____________ Age:________ Grade:________ Phone #:________________________

Parent/Guardian:_________________________________________ Home Phone #:_______________

Address:____________________________________________________________________________

Father’s Employer:______________________________ Business Phone #:_______________________

Mother’s Employer:_____________________________ Business Phone #:_______________________

Family Doctor:______________________________ Phone #:_____________________________

Family Dentist:_________________________________ Phone #:____________________________

Preferred Hospital:______________________________ Phone #:____________________________

Known Allergies:_______________________________________________________________________

***If parents/guardians cannot be reached, please list two secondary individuals that should be contacted if an emergency occurs:

1. Name:______________________________ Phone #:_____________________________

2. Name:_________________________________ Phone #:____________________________

GRANT CONSENT:
I give my consent for emergency medical or dental treatment for my child who may become injured or ill while under school authority. I understand this authorization does not cover any surgery unless medical opinions of two other licensed physicians or dentists concurring in the necessities for such surgery are obtained prior to the performance of such surgery.

_________________________________________      _________________________________________
NAME OF INSURANCE COMPANY               SIGNATURE OF PARENT/GUARDIAN

 ****************POLICY NUMBER************    DATE
INFORMED CONSENT FOR EVALUATION RELATED TO SPORT PARTICIPATION AND AUTHORIZATION TO RELEASE INFORMATION

________________________ ("Participant") is seeking to participate in a sport activity ("Activity") with ____________________ (Club/Team/School, referred to as "Program"). The Program has contracted with Children’s Mercy Hospital to provide certain services related to the Program.

By signing this Informed Consent for Evaluation Related to Sport Participation and Authorization to Release Medical Information ("Consent"), I hereby authorize a Children’s Mercy Hospital physician, nurse practitioner, athletic trainer, or other allied health personnel (collectively referred to as "Practitioner") acting on behalf of the Program to perform assessment, evaluation, examination, treatment or rehabilitation of the Participant (referred to as “Sports Medicine Service(s)”). The Sports Medicine Services provided pursuant to the agreement between the Program and Children’s Mercy Hospital may also include pre-participation physical examinations ("PPE"), baseline and post-concussion testing, and Electrocardiogram evaluation ("EKG").

I understand that a PPE is for screening purposes only and is not a complete physical examination to diagnose diseases or certain medical conditions, nor does it include all elements of a well-patient examination, such as vision or hearing screenings, social development and activity, cognitive development and academics, updating immunizations, preventive health recommendations, and laboratory testing.

I certify that I have and will provide the Participant’s medical history truthfully and to the best of my ability. I understand that truthful responses are necessary for the evaluation and safety of the Participant.

I understand that neither the PPE nor any other Sports Medicine Service provided by any Practitioner guarantees Activity participation results nor prevents future injury. I further understand that the PPE and any other examination, evaluation, and testing performed by a Practitioner carries with it the risk of misdiagnosis and injury and that results are not guaranteed. Despite these risks, I authorize Practitioner to provide Sports Medicine Services as identified above to Participant related to the Activity. I have had the opportunity to have any questions regarding the Sports Medicine Service(s) answered to my satisfaction. I knowingly and voluntarily consent to Participant receiving the Sports Medicine Services by The Children’s Mercy Hospital related to the Program and Activity.

I further recognize that certain information included as part of any Sports Medicine Service provided to Participant may be shielded from disclosure by certain confidentiality protections, including the Family Educational Rights and Privacy Act ("FERPA"). I authorize the Program to release the PPE form and other information related to participation in the Program, including any information on Participant to healthcare providers necessary for proper treatment of Participant including to Children’s Mercy Hospital’s workforce members (employees, physicians, nurses, etc.). I understand the information may be released orally or in the form of
copies of written records. I have a right to inspect any written records released pursuant to this Authorization. I understand I may revoke this Authorization upon providing written notice to the Program. I further understand that until this revocation is made, this Authorization shall remain in effect.

I hereby release The Children’s Mercy Hospital and its employees, including Practitioner(s) acting on behalf of the Program, from any and all liability that may arise from the Sports Medicine Services provided by any Practitioner related to Participant’s participation in the Activity and medical advice provided by a Practitioner. I further agree to defend, indemnify, and hold The Children’s Mercy Hospital and its employees, including Practitioner(s) acting on behalf of the Program, harmless for any injuries or liability related to Practitioner’s clearance or non-clearance of Participant to participate in the Activity.

Participant or the Legal Guardian, if the Participant is under the age of 18 and cannot otherwise legally consent on his/her own behalf, must sign below:

Participant Signature (if 18 or older): __________________________ Date: ________
                                   Time: ________

Legal Guardian Signature: __________________________________________ Date: ________
                                   Time: ________

Legal Guardian Relationship to Participant: _________________________

Participant Date of Birth: ______________
Participant and Parent/Guardian Address: __________________________
Home Phone: _______________________
Work/Cell Phone: _________________
Alternative Phone: _______________