

# HISTORY FORM

**- To be kept on file in Physicians Office -**

*Please complete this page prior to the examination.*

**Student Name** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Male** \_\_\_\_\_ **Female** \_\_\_\_\_

- |  | YES | NO  |  | YES | NO  |
|--|-----|-----|--|-----|-----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   | ___ | ___ | 23. Has a doctor ever told you that you have asthma or allergies?                                      | ___ | ___ |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?   | ___ | ___ | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                       | ___ | ___ |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines?  | ___ | ___ | 25. Is there anyone in your family who has asthma?   | ___ | ___ |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?  | ___ | ___ | 26. Have you ever used an inhaler or taken asthma medicine?  | ___ | ___ |
| 5. Have you ever passed out or nearly passed out DURING exercise?  | ___ | ___ | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?         | ___ | ___ |
| 6. Have you ever passed out or nearly passed out AFTER exercise?   | ___ | ___ | 28. Have you had infectious mononucleosis (mono) within the last month?                                | ___ | ___ |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  | ___ | ___ | 29. Do you have any rashes, pressure sores, or other skin problems?                                    | ___ | ___ |
| 8. Does your heart race or skip beats during exercise?   | ___ | ___ | 30. Have you had a herpes skin infection?  | ___ | ___ |
| 9. Has a doctor ever told you that you have (check all that apply):  |     |     | 31. Have you had a head injury or concussion?  | ___ | ___ |
| ___ High blood pressure      ___ A heart infection   |     |     | 32. Have you been hit in the head and been confused or lost your memory?                               | ___ | ___ |
| ___ A heart murmur          ___ High cholesterol   |     |     | 33. Have you ever had a seizure?   | ___ | ___ |
| 10. Has a doctor ever ordered a test for your heart? (e.g. ECG, echocardiogram)  | ___ | ___ | 34. Do you have headaches with exercise?   | ___ | ___ |
| 11. Has anyone in your family died for no apparent reason?   | ___ | ___ | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ___ | ___ |
| 12. Does anyone in your family have a heart problem?   | ___ | ___ | 36. Have you ever been unable to move your arms or legs after being hit or falling?                    | ___ | ___ |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?   | ___ | ___ | 37. When exercising in the heat, do you have severe muscle cramps or become ill?                       | ___ | ___ |
| 14. Does anyone in your family have Marfan syndrome?   | ___ | ___ | 38. Do you do someone in your family have sickle cell trait or sickle cell disease?                    | ___ | ___ |
| 15. Have you ever spent the night in a hospital?   | ___ | ___ | 39. Have you had any problems with your eyes or vision?  | ___ | ___ |
| 16. Have you ever had surgery?   | ___ | ___ | 40. Do you wear glasses or contact lenses?   | ___ | ___ |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game? If yes, where? _____                          | ___ | ___ | 41. Do you wear protective eyewear, such as goggles or a face shield?                                  | ___ | ___ |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes, where? _____   | ___ | ___ | 42. Are you happy with your weight?  | ___ | ___ |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, where? _____ | ___ | ___ | 43. Are you trying to gain or lose weight?   | ___ | ___ |
| 20. Have you ever had a stress fracture?   | ___ | ___ | 44. Has anyone recommended you change your weight or eating habits?                                    | ___ | ___ |
| 21. Have you had an x-ray for atlantoaxial (neck) instability?   | ___ | ___ | 45. Do you limit or carefully control what you eat?  | ___ | ___ |
| 22. Do you regularly use a brace or assistive device?  | ___ | ___ | 46. Do you have any concerns that you would like to discuss with a doctor?                             | ___ | ___ |
|  |     |     | <b>FEMALES ONLY</b>  |     |     |
|  |     |     | 47. Have you ever had a menstrual period?  | ___ | ___ |
|  |     |     | 48. How old were you when you had your first menstrual period? _____                                   |     |     |
|  |     |     | 49. How many periods have you had in the last year? _____  | ___ | ___ |

# PHYSICAL EXAMINATION FORM

- To be kept on file in Physicians Office -

**STUDENT'S NAME** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **GRADE** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ Pulse \_\_\_\_\_

Vision (R) 20/\_\_\_\_ (L) 20/\_\_\_\_ Corrected Y N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

	Normal	Abnormal Findings		Normal	Abnormal Findings
Appearance			<b>Musculoskeletal</b>		
Eyes / ears					
Nose / Throat			Neck		
Hearing			Back		
Lymph nodes			Shoulder		
Heart			Elbow / forearm		
Murmurs			Wrist/hand/fingers		
Pulses			Hip / thigh		
Lungs			Knee		
Abdomen			Leg / ankle		
Genitourinary			Foot / toes		
Skin					

NOTES: \_\_\_\_\_

\_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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

# PARENTAL CONSENT FORM

**NAME OF STUDENT** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **PLACE OF BIRTH** \_\_\_\_\_

## STUDENT AND PARENT CONSENT

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;
- 2) Understand and agree that (a) by this Consent Form the NSAA has provided notification to the Parent and the Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle stains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility;
- 3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,
- 4) Consent and agree to (a) the disclosure by Gross Catholic to the NSAA, and subsequent disclosure by the NSAA of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g. full-time or part-time), participation in officially recognized activities and sports, weight and height, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such photographs and recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

## TRANSPORTATION AGREEMENT

During the high school athletic season student-athletes will need to occasionally travel between Gross Catholic High School and other schools or practice locations within the Omaha metropolitan area. At times it shall be the responsibility of each parent and/or guardian to insure their child's means of transportation to various athletic contests and events. On trips outside of the Omaha metropolitan area all students are required to travel to and from the event in a school or rental vehicle. Exceptions are discouraged. If an exception is needed, it must be cleared through one of the high school administrators in advance.

## ATHLETIC INSURANCE COVERAGE

Gross Catholic High School, acting for members of the athletic squad, makes available an Athletic Injury Benefit Plan for insurance coverage, but the school does NOT have any coverage for those not enrolled in this plan. The student or parent pays for the total premium. The purpose of such coverage is to assist in the cost of treatment of accidental injury. Payments are in addition to any payment by another insurance company for the same injury. **Squad members must have insurance coverage to participate.**

- **I/We acknowledge that I/We have read the Student/Parent Consent and Transportation agreement, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in the Student/Parent Consent above and understanding the potential risk of injury to my Student, I/we hereby give my/our permission for the student named on this form to practice and compete for Gross Catholic High School in activities approved by the NSAA, except those listed hereafter \_\_\_\_\_.**
- **I/We have read the Athletic Insurance Coverage and verify that our student is adequately insured against injury that might be incurred during athletic participation**  
**OR**  
\_\_\_\_\_ *I shall participate in the Athletic Benefit Injury Plan. Information brochures are available from the school office upon request.*

**Signature of Parent/Guardian** \_\_\_\_\_

**Signature of Student** \_\_\_\_\_ **Date** \_\_\_\_\_

Due to privacy and HIPAA issues, the NSAA's Sports Medicine Advisory Committee has recommended that schools utilize a different procedure for sports physicals. In the past, the medical history and actual physical form were filed with the student's high school - a practice that has been challenged as infringing on privacy and HIPPA regulations. The attached 4 part form includes (1) Clearance Form; (2) Parental Consent Form; (3) History Form; (4) the actual Physical Examination Form. It is requested that the examining physician retain on file the **HISTORY FORM and the PHYSICAL EXAMINATION FORM** with only the **CLEARANCE FORM and the PARENTAL CONSENT FORM** being returned to the student to be placed on file in the school office.

## INSTRUCTIONS TO STUDENTS / PARENTS:

Students / Parents must complete the **PHYSICAL EXAMINATION HISTORY FORM** as well as signing the **STUDENT AND PARENT CONSENT FORM** (both parent and student must sign this form) prior to seeing the physician for their physical exam. The physician will keep on file in their office, the **History & Physical Exam Form**; the **Clearance & Parental Consent Form** **MUST** be returned to the school office.

# CLEARANCE FORM

## GROSS CATHOLIC HIGH SCHOOL

***- This form to be returned to the School Office -***

Name \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

**CLEARED WITHOUT RESTRICTION**

**CLEARED WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR \_\_\_\_\_**

**NOT CLEARED FOR \_\_\_\_\_ ALL SPORTS \_\_\_\_\_ CERTAIN SPORTS:**

**RECOMMENDATION: \_\_\_\_\_**

### EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**NAME OF PHYSICIAN** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**SIGNATURE OF PHYSICIAN** \_\_\_\_\_

**DATE** \_\_\_\_\_