BLISSFIELD COMMUNITY SCHOOLS

PREPARTICIPATION HEALTH EVALUATION

PERSONAL INFORMATION

Name of Student ______________________ Sex_____ Grade Level 2018-19_____ Age ____ Date of Birth ______________

Street Address: ______________________ City__________________ Zip___________ Home Phone: ______________

Father's Name: ______________________ Address if different: ______________________

Mother's Name : ______________________ Address if different: ______________________

Family Physician: ______________________ Office Phone: ______________________

In case of emergency, parents will be contacted first. Please list a non-parent contact:

Name ______________________ Relationship ______________________

Address ______________________ Phone (H) ______________ (W) ______________

INSURANCE STATEMENT/EQUIPMENT RESPONSIBILITY/ATHLETIC CODE/MEDICAL TREATMENT 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.

**He/she has my permission to accompany the team as a member on its out of town trips.

**I am aware that Blissfield Community Schools does not have insurance that will cover any athletic injury, medical fees, hospital expenses, ambulance cost, etc. and am totally responsible all medical expenses incurred by my son/daughter while participating in athletics at Blissfield Community Schools.

**I further agree and understand that Blissfield Community Schools, or any supervisor will not be held responsible for any sickness or injury caused directly or indirectly from participating in the program.

**I also agree to reimburse the Athletic Department for equipment/uniforms issued to my son/daughter should it not be returned.

**My son/daughter and I have read the athletic code and our participation in athletics demonstrates our willingness to be held accountable by the rules of the Athletic Code. (Copies of the Athletic Code are available on line at: www.blissfieldathletics.com)

**I understand that this entire form will be used for any emergency medical treatment my child might require.

****I also 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.**

I hereby state that, to the best of my knowledge, the above information is correct and agree to abide by all conditions stated above.

ATHLETE'S SIGNATURE ______________________ SIGNATURE OF PARENT/GUARDIAN ______________________

DATE ______________ DATE ______________

**We have our own insurance policy. Yes No Name of company ______________________

ATHLETE MEDICAL HISTORY

Check "Yes" or "No". Explain "Yes" answers below.

1. Has a Doctor ever denied or restricted your participation in sports for any reason? Yes_____No_____
2. Do you have any ongoing medical conditions (asthma/anemia/diabetes/other)? Yes_____No_____
3. Have you ever had surgery or spent the night in the hospital? Yes_____No_____
4. Have you ever passed out or nearly passed out during or after exercise? Yes_____No_____
5. Do you get lightheaded or feel more short of breath than expected during exercise? Yes_____No_____
6. Does your heart ever race or skip beats during exercise? Yes_____No_____
7. Has a Doctor ever told you that you have high blood pressure, heart murmur? Yes_____No_____
8. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? Yes_____No_____
9. Have any members of your family younger than 50 had a heart attack, heart problem or died unexpectedly? Yes_____No_____
10. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a game? Yes_____No_____
11. Have you ever had a broken or fractured bone or dislocated joints? Yes_____No_____
12. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy or a brace? Yes_____No_____
13. Have you ever had a stress fracture? Yes_____No_____
14. Are you missing any recommended vaccines (T-dap, flu, MCV4, HPV, Varicella, MMR)? Yes_____No_____
15. Were you born without or are you missing an organ (kidney, eye, spleen)? Yes_____No_____

ATHLETE MEDICAL HISTORY – con't

Name ______________________________ Date of Birth ______________

16. Have you ever had a head injury or concussion? Yes_____No_____
17. Do you wear protective eyewear, such as googles or a face shield? Yes_____No_____
18. Does anyone in your family have sickle cell trait or disease? Yes_____No_____
19. Have you had infectious mononucleosis (mono) in the last month? Yes_____No_____
20. Do you have any concerns you would like to discuss with a doctor? Yes_____No_____

Explain "Yes" answers here: ______________________________

To be completed by athlete/parent prior to physical:

HAVE YOU EVER HAD: YES/NO	HAVE YOU EVER HAD: YES/NO	DO YOU NOW HAVE: YES/NO
Fainting	Kidney Disease	Painful Joints
Diphtheria	Tuberculosis	Backaches
Scarlet Fever	Jaundice	Pounding of Heart
Rheumatism	Sickle-Cell Anemia	Shortness of Breath
Rupture	Frequent Nosebleeds	Frequent Urination
Rheumatic Fever	Frequent Sore Throats	Cough
Poliomyelitis	Frequent Stomach Pains	Blurred Vision
Pneumonia	Convulsions	Headaches

PHYSICAL EXAMINATION & MEDICAL CLEARANCE

Height _______ Weight ________ Pulse ________ BP _______ Vision: Left 20/_____ Right 20/______ Corrected Y / N

To be completed by examining MD, DO, Physician's Assistant on day of physical.

SYSTEM	NORMAL	ABN.	SYSTEM	NORMAL	ABN
Appearance			Chest		
Ears/Nose/Throat			Lungs		
Eyes			Heart		
Lymph Nodes			Abdomen		
Pulses			Hernia		
Teeth-Cavities			Genitalia/Testicular Exam		
Orthopedic			Neurologic		
Skin			Muscular		

RECOMMENDATIONS: ______________________________

I have examined the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participation as outlined below.

___ 1) Participate in all school interscholastic activities without restrictions

___ 2) Not Cleared for: ___ All Sports ___ Specific Sports: (cross out sports NOT cleared for)

BASEBALL—BASKETBALL—BOWLING---COMPETITIVE CHEER—CROSS COUNTRY—FOOTBALL—GOLF— SOCCER—SOFTBALL—TRACK—VOLLEYBALL—WRESTLING

___ 3) Requires further evaluation before a final recommendation can be made

Additional recommendations for the school or parents: ______________________________

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A CURRENT YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15, 2018

SIGNATURE OF EXAMINER: X ______________________________

CIRCLE ONE: MD DO PA NP

PRINTED NAME OF EXAMINER: ______________________________

DATE: ______________