Athlete's Name: _____ DOB_____

Consent for Treatment. I, the athlete, or my representative, wishes to participate in the Reid Health Sport Medicine High School Athletic Physicals program. I understand that some of the individuals that are providing all or a portion of the examination may not be employees or agents of Reid Health (Reid Health), Reid Rehabilitation Services (Reid Rehab) or Reid Health Physician Associates (RHPA). I authorize the participating allied health personnel and physician, regardless of their employment status with Reid Health, Reid Rehab or RHPA to render a pre-participation athletic physical examination on me. I understand that Reid Health, Reid Rehab and RHPA are not responsible for those individuals who are not their employee. I understand that the practice of medicine is not an exact science and acknowledge that no guarantee has been made to me as to the result of this examination. I understand that it is my right to consent or to refuse consent for this examination I understand that the information and forms for this examination will be forwarded to the athlete's school system and maintained in part by Reid Health. I understand that Reid Health, Reid Rehab and RHPA will not be responsible for any valuables brought to any Reid Health, Reid Rehab or RHPA facility by me.
I have read or had the opportunity to read the Consent for Treatment or it has been fully explained to me, and I am satisfied that I understand its content and significance. My consent is given freely, voluntarily and without reservation.

_____

Patient or Responsible Person's signature Date/Time
(If 18 years or older and appropriate)
Reid Health
Richmond, IN 47374 (765) 983-3000
General Consent for Pre-participation
Athletic Physical Examination

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to examination. The examiner should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. 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: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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)?		
14. 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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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** _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. 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, 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, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____ / ____ (____ / ____) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
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 • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
Mmusculoskeletal		
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 completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). *(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10*

Name of physician (print/type) (MD, DO, NP, or PA) _____ Date _____

Address _____ Phone _____

Signature of physician (MD, DO, NP, or PA) _____ License # _____

REID SPORTS MEDICINE ATHLETE DEMOGRAPHICS FORM

(Please Print Clearly)

Nickname _____ Gender M F DOB _____ Year in school 5 6 7 8 Fr So Jr Sr 5thYear

Primary Address _____ City _____ State _____ Zip _____

Home Phone (leave blank if no home phone) _____

Parent's Cell # (____) _____ Student's Cell # (____) _____

Secondary Address _____ City _____ State _____ Zip _____

Sport 1 _____ Sport 2 _____ Sport 3 _____ Sport 4 _____

By listing a person as a contact you authorize the release of medical information to that individual. List in the order you would prefer to be contacted. Check box to authorize us to leave medical information on voice mail at this phone number.

	Contact name	Relation	Home Phone	Cell Phone	Work Phone	E-Mail
1			☐ ( )	☐ ( )	☐ ( )	
2			☐ ( )	☐ ( )	☐ ( )	
3			☐ ( )	☐ ( )	☐ ( )	
4			☐ ( )	☐ ( )	☐ ( )	

Other individuals that **are** authorized to receive medical information _____

_____

Specific individuals that **are not** authorized to receive medical information (i.e. estranged family members)

_____

Medical and Environmental Allergies

_____

Important medical alerts

Regular medications

_____

Primary Insurance provider _____ **Policy #** _____ **Group #** _____ **Policy Holder** _____

Secondary Insurance provider _____ **Policy #** _____ **Group #** _____ **Policy Holder** _____

Primary Physician _____ **Primary Dentist** _____ **Preferred Hospital Emergency Dept.** _____

Legal Name

First ___

___

___

___

___

___

___

___

___

___

Middle Initial ___

___

Last ___

___

___

___

___

___

___

___

___

___

CONCUSSION and SUDDEN CARDIAC ARREST
ACKNOWLEDGEMENT AND SIGNATURE FORM FOR PARENTS AND STUDENT ATHLETES

Student Athlete's Name (Please Print): _____

Sport Participating In (Current and Potential): _____

School: _____ Grade: _____

IC 20-34-7 and IC 20-34-8 require schools to distribute information sheets to inform and educate student athletes and their parents on the nature and risk of concussion, head injury and sudden cardiac arrest to student athletes, including the risks of continuing to play after concussion or head injury. These laws require that each year, before beginning practice for an interscholastic sport, a student athlete and the student athlete's parents must be given an information sheet, and both must sign and return a form acknowledging receipt of the information to the student athlete's coach.

IC 20-34-7 states that an interscholastic student athlete, in grades 5-12, who is suspected of sustaining a concussion or head injury in a practice or game, shall be removed from play at the time of injury and may not return to play until the student athlete has received a written clearance from a licensed health care provider trained in the evaluation and management of concussions and head injuries, and at least twenty-four hours have passed since the injury occurred.

IC 20-34-8 states that a student athlete who is suspected of experiencing symptoms of sudden cardiac arrest shall be removed from play and may not return to play until the coach has received verbal permission from a parent or legal guardian for the student athlete to return to play. Within twenty-four hours, this verbal permission must be replaced by a written statement from the parent or guardian.

Parent/Guardian - please read the attached fact sheets regarding concussion and sudden cardiac arrest and ensure that your student athlete has also received and read these fact sheets. After reading these fact sheets, please ensure that you and your student athlete sign this form, and have your student athlete return this form to his/her coach.

As a student athlete, I have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

_____ _____
(Signature of Student Athlete) (Date)

I, as the parent or legal guardian of the above named student, have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

_____ _____
(Signature of Parent or Guardian) (Date)

SUDDEN CARDIAC ARREST

A Fact Sheet for Parents

FACTS

Sudden cardiac arrest is a rare, but tragic event that claims the lives of approximately 500 athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest.

WARNING SIGNS

There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

Warning signs can include a complaint of:

- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

EMERGENCY SIGNS – Call EMS (911)

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

How can I help my child prevent a sudden cardiac arrest?

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, parents can assist student athletes prevent a sudden cardiac arrest by:

- Ensuring your child knows about any family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Ensuring your child has a thorough pre-season screening exam prior to participation in an organized athletic activity
- Asking if your school and the site of competition has an automatic defibrillator (AED) that is close by and properly maintained
- Learning CPR yourself
- Ensuring your child is not using any non-prescribed stimulants or performance enhancing drugs
- Being aware that the inappropriate use of prescription medications or energy drinks can increase risk
- Encouraging your child to be honest and report symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

What should I do if I think my child has warning signs that may lead to sudden cardiac arrest?

1. *Tell your child's coach about any previous events or family history*
2. *Keep your child out of play*
3. *Seek medical attention right away*

Developed and Reviewed by the Indiana Department of Education's Sudden Cardiac Arrest Advisory Board
(1-7-15)

PREPARTICIPATION PHYSICAL EVALUATION

CONSENT & RELEASE CERTIFICATE

STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. I have read the IHSAA Eligibility Rules (*next page or on back*) and know of no reason why I am not eligible to represent my school in athletic competition.

B. If accepted as a representative, I agree to follow the rules and abide by the decisions of my school and the IHSAA.

C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless my school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against my school, the schools involved or the IHSAA because of any accident or mishap involving my athletic participation.

D. I consent to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me, including but not limited to any claims or disputes involving injury, eligibility or rule violation.

E. I give the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use my picture or image and any sound recording of me, in all forms and media and in all manners, for any lawful purposes.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION. (to be signed by student)

Date: _____ Student Signature: (X) _____

Printed: _____

II. PARENT/GUARDIAN/EMANCIPATED STUDENT CONSENT, ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. Undersigned, a parent of a student, a guardian of a student or an emancipated student, hereby gives consent for the student to participate in the following interschool sports ***not marked out:***
Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling.
Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball.

B. Undersigned understands that participation may necessitate an early dismissal from classes.

C. Undersigned consents to the disclosure, by the student's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning the student.

D. Undersigned knows of and acknowledges that the student knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and chooses to accept any and all responsibility for the student's safety and welfare while participating in athletics. With full understanding of the risks involved, undersigned releases and holds harmless the student's school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agrees to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving the student's athletic participation.

E. Undersigned consents to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me or the student, including but not limited to any claims or disputes involving injury, eligibility, or rule violation.

F. Undersigned gives the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes.

G. Please check the appropriate space:

- ☐ The student has school student accident insurance.
- ☐ The student has adequate family insurance coverage.
- ☐ The student has football insurance through school.
- ☐ The student does not have insurance.

Company: _____ Policy Number: _____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.
(to be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Date: _____ Parent/Guardian/Emancipated Student Signature: (X) _____

Printed: _____

Date: _____ Parent/Guardian Signture: (X) _____

Printed: _____

Reid
Sports Medicine

REID HEALTH CONSENT FOR TREATMENT, HEALTH CARE OPERATIONS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR THE SCHOOL YEAR 2018-19.

I _____ (print or type name) consent to the provision of care.
(Athlete's Name)

- I understand that this care may include medical treatment, special tests, exams, evaluation, treatment and rehabilitation of an injury, illness or disability that may impact my ability to participate in athletics.. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.
- I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physicians, athletic trainers, family physicians, school nurses and emergency medical personnel. As such, I understand that there will be open communication/access to the medical record, verbally, electronically, or in print, including but not limited to diagnosis, severity, playing status, plan of care, restrictions and limitations among the medical providers involved in my care. Under the direction of a certified athletic trainer, student athletic trainers may also provide care.
- I authorize Reid Health to provide information related to my care to my family/school/team physician, school nurse, coaches, athletic department personnel, school principals, EMS personnel, and such persons as-needed for them to provide consultation, treatment, establish a plan of care and determine eligibility.
- I understand that release of my health record(s) will only be for the purpose stated on this form.
- I understand that the health record(s) released by Reid Health may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Reid Health and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that the Athletic Trainer may contact me via cell phone or text, but will not communicate confidential medical information via text.
- I understand that this Authorization is in effect from the date of the signature extending until July 31st of the year listed as school year above.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to Reid Hospital's Sports Health Manager. I understand that the revocation does not apply to any release of my health record(s) that may have taken place prior to the date the request to revoke the Authorization is received.
- I understand that the Notice of Privacy Practices document is posted in the Athletic Training Room at my school. I also understand that a copy of this Notice is available to me upon my request or by visiting the hospital's website at www.reidhealth.org

I agree to the release of information to the phone numbers, accounts and individuals listed as contacts in the Reid Sports Medicine Athlete Demographic form, but not limited to, injury occurrence, medical status, playing status and treatment plan by the following means:

Athlete's Signature Date / Time

**Parent or Guardian Signature Date / Time

**Parent or Guardian signature not necessary for College Students over the age of eighteen (18). Parent or Guardian signature is necessary for all high school students and all minors under eighteen (18) years of age and not an emancipated minor or otherwise not competent to give consent.

CENTERVILLE-ABINGTON COMMUNITY SCHOOLS 2018-19
STUDENT ATHLETE EMERGENCY CARD

SPORTS: _____

STUDENT'S LAST NAME: _____ FIRST: _____ MI: _____

GENDER: _____ BIRTHDATE: _____ HOME PHONE: _____

ADDRESS: _____ CITY, STATE ZIP: _____

MOTHER'S NAME: _____ CELL PHONE: _____

FATHER'S NAME: _____ CELL PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

MEDICAL ALERTS/INFORMATION: _____

INSURANCE COMPANY NAME: _____ POLICY NUMBER: _____

I hereby give my permission to the school principal or his/her designee to administer first aid to my child if I am unavailable or otherwise unable to provide authorization directly. In case of a medical emergency, my child may be transported to the hospital. It is understood that all expenses incurred in such situations shall be my responsibility and not the CACS nor any of its Board of Education Members, administration, faculty and other school personnel. This authorization is valid for the current school year or until such time I withdraw the authorization.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE