

Cincinnati Public Schools Grades 7 & 8 Parental Medical Authorization to Participate Form



(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____
Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____
Street City Zip Telephone

Parent(s) or Guardian(s) Name _____
 Address (if different than student) _____
Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.						
1. Have you had a medical illness or injury since your last checkup or sports physical?	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have an ongoing or chronic illness?			<input type="checkbox"/>	<input type="checkbox"/>		
2. Have you ever been hospitalized overnight?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had surgery?			<input type="checkbox"/>	<input type="checkbox"/>		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			<input type="checkbox"/>	<input type="checkbox"/>		
4. Do you think you are in good health?			<input type="checkbox"/>	<input type="checkbox"/>		
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?			<input type="checkbox"/>	<input type="checkbox"/>		
6. Have you ever had a rash or hives develop during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever passed out during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been dizzy during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had chest pain during or after exercise?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you get tired more quickly than your friends do during exercise?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had racing of your heart or skipped heartbeats?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you had high blood pressure or high cholesterol?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been told you have a heart murmur?			<input type="checkbox"/>	<input type="checkbox"/>		
Has any family member or relative died of heart problems or of sudden death before age 50?			<input type="checkbox"/>	<input type="checkbox"/>		
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you had a severe heart infection (for example, myocarditis or pericarditis)?			<input type="checkbox"/>	<input type="checkbox"/>		
Is there a family history of Marfan's Syndrome?			<input type="checkbox"/>	<input type="checkbox"/>		
Has a physician ever denied or restricted your participation in sports for any heart problem?			<input type="checkbox"/>	<input type="checkbox"/>		
7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?			<input type="checkbox"/>	<input type="checkbox"/>		
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?			<input type="checkbox"/>	<input type="checkbox"/>		
9. Have you ever had a head injury or concussion?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been knocked out, become unconscious or lost your memory?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a seizure?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you have frequent or severe headaches?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had numbness or tingling in your arms, hands, legs or feet?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a stinger, burner or pinched nerve?			<input type="checkbox"/>	<input type="checkbox"/>		
10. Have you ever become ill from exercising in the heat?			<input type="checkbox"/>	<input type="checkbox"/>		
11. Do you cough, wheeze or have trouble breathing during or after activity?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you have asthma?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you have seasonal allergies that require medical treatment?			<input type="checkbox"/>	<input type="checkbox"/>		
12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?			<input type="checkbox"/>	<input type="checkbox"/>		
13. Have you had any problems with your eyes or vision?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you wear glasses, contacts or protective eyewear?			<input type="checkbox"/>	<input type="checkbox"/>		
14. Have you ever had a sprain, strain or swelling after injury?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you broken or fractured any bones or dislocated any joints?			<input type="checkbox"/>	<input type="checkbox"/>		
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?			<input type="checkbox"/>	<input type="checkbox"/>		
<i>If yes, check the appropriate box and explain below.</i>						
<input type="checkbox"/> Head	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Knee			
<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Finger	<input type="checkbox"/> Shin/calf			
<input type="checkbox"/> Back	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hip	<input type="checkbox"/> Ankle			
<input type="checkbox"/> Chest	<input type="checkbox"/> Wrist	<input type="checkbox"/> Thigh	<input type="checkbox"/> Foot			
<input type="checkbox"/> Shoulder						
15. Do you want to <input type="checkbox"/> weigh more or less than you do now?			<input type="checkbox"/>	<input type="checkbox"/>		
Do you lose weight regularly to meet weight requirements for your sport?			<input type="checkbox"/>	<input type="checkbox"/>		
16. Do you feel stressed out?			<input type="checkbox"/>	<input type="checkbox"/>		
17. Record the dates of your most recent immunizations (shots) for:						
Tetanus _____	Measles _____					
Hepatitis B _____	Chickenpox _____					
18. FEMALES ONLY						
When was your first menstrual period? _____						
When was your most recent menstrual period? _____						
How much time do you usually have from the start of one period to the start of another? _____						
How many periods have you had in the last year? _____						
What was the longest time between periods in the last year? _____						
19. ALL PARTICIPANTS						
Explain "Yes" answers here: _____						

I/We consent to the participation of the above-named student in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by school authorities. I/We have read and signed the Release of Liability/Informed Consent/Assumption of Risk Waiver Form required by the Cincinnati Public Schools before my son/daughter may be permitted to participate.

Student Signature _____ Parent or Guardian Signature _____ Date _____

The student has family insurance Yes No; If yes, family insurance co. name, policy #: _____

NOTE: This Parental Medical Authorization to Participate Form Must Be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Association, the American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal ____ Unequal ____

	Normal	Abnormal Findings	Initials*
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MEDICAL

Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Clearance

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- _____
- _____
- Not cleared for: _____ Reason: _____
- Recommendations: _____
- _____
- _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

 Physician's Name and Address (stamp or print)

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

 Examiner's Signature

 Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination