SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

NAME _____ AGE ____ GRADE ____ DATE_____

ADDRESS _____ PHONE NO. _____

DATE OF BIRTH _____ SEX: M _____ F _____

SPORTS _____

PHYSICIAN _____ SCHOOL _____

This health history should be completed by the athlete and parent **BEFORE** the examination.

	YES	NO
1. Have you ever had an illness that:		
a. required you to stay in the hospital?	___	___
b. lasted longer than a week?	___	___
c. caused you to miss 3 days of practice or a competition?	___	___
d. is related to allergies (hay fever, asthma, insect stings)?	___	___
e. required an operation?	___	___
f. is chronic (asthma, diabetes)?	___	___
2. Have you ever had an injury that:		
a. required you to go to an emergency room or go see a doctor?	___	___
b. required you to stay in the hospital?	___	___
c. required X-rays?	___	___
d. caused you to miss 3 days of practice or competition?	___	___
e. required an operation?	___	___
3. Do you take any medications or pills?	___	___
If so, list them and what they're for:		
_____		
_____		
4. Have any members of your family under age 50 had a heart attack, heart problem, or died unexpectedly?	___	___
5. Have you ever:		
a. been dizzy or passed out during or before exercise?	___	___
b. been unconscious or had a concussion?	___	___
6. Are you able to run 1/2 mile without stopping (2 times around a track)?	___	___
7. Do you:		
a. wear glasses or contacts?	___	___
b. wear dental bridges or braces	___	___
8. Have you ever had a heart murmur, high blood pressure or a heart abnormality?	___	___
9. Do you have any allergies to medicine?	___	___
10. Are you missing a kidney or testicle?	___	___

11. Are you worried about any problems or conditions at this time? YES ___ NO ____

If so, explain: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I acknowledge I have read, and understand, the medical release form, parental consent form, the warning of dangers, and the standards which govern athletics rules and regulations. I have received and read the following regulations: Academic Eligibility, Alcohol, Tobacco & Illegal Drugs and Eligibility Standards and Violations.

Signature of athlete _____ **Date** _____

Signature of parent _____ **Date** _____

OVER - MUST SIGN FORM ON BACK OF THIS PAGE!

Comments regarding abnormal findings:

PHYSICAL EXAMINATION RECORD

Station 2	Normal	Result	Initials
Height	_____	_____	_____
Weight	_____	_____	_____
Pulse	_____	_____	_____
Blood Pressure	_____	_____	_____

Station 3 — Vision Screening

Right _____ ____/____ corrected _____ uncorrected _____

Left _____ ____/____ corrected _____ uncorrected _____

Station 4	Normal	Abnormal Findings	Initials
Eyes	_____	_____	_____
Ears, Nose, Throat	_____	_____	_____
Mouth & Teeth	_____	_____	_____
Neck	_____	_____	_____

Physical Maturity (Tanner Stage) circle one 1. 2. 3. 4. 5

Station 5	Normal	Abnormal Findings	Initials
Cardiovascular	_____	_____	_____
Chest & Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia-Hernia (male)	_____	_____	_____

Station 6	Normal	Abnormal Findings	Initials
Musculoskeletal Exam	_____	_____	_____
a. Neck	_____	_____	_____
b. Spine	_____	_____	_____
c. Shoulders	_____	_____	_____
d. Arms/hands	_____	_____	_____
e. Hips	_____	_____	_____
f. Thighs	_____	_____	_____
g. Knees	_____	_____	_____
h. Ankles	_____	_____	_____
i. Feet	_____	_____	_____
Neuromuscular	_____	_____	_____

PARTICIPATION RECOMMENDATIONS:

____ 1. NO ATHLETIC PARTICIPATION

____ 2. LIMITED PARTICIPATION, Specific exclusions:

____ 3. FULL UNLIMITED PARTICIPATION

____ 4. CLEARANCE WITHHELD UNTIL:

_____ _____ _____

Physician's Signature DATE PHONE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Immaanuel Lutheran School ("ILS")

PART I **Identification**

Student's Name_____ Date of Birth_____

Disclosing Party_____
(Name of Hospital, Clinic, or Doctor)

PART II **Authorization for Release of Health Information**

I hereby authorize the Disclosing Party and its agents to disclose health information about the Student to ILS

1. **YOU ARE AUTHORIZED TO DISCLOSE THE FOLLOWING HEALTH INFORMATION:**
   - ☐ Information about a particular admission, treatment or episode of care. Specify:_____
   - ☐ The following health information:_____
   - ☐ All health information about Student and any information requested by ILS

2. **DOES THIS AUTHORIZATION INCLUDE—**

☐Yes	☐ No	Alcohol/drug abuse information if part of the specified record
☐Yes	☐ No	Mental health information if part of the specified record
☐Yes	☐ No	HIV/AIDS – related information (including test results) if part of the specified record
☐Yes	☐ No	Genetic testing information if part of the specified record
☐Yes	☐ No	Psychotherapy notes (Note – You cannot combine an authorization to disclose psychotherapy Notes with any other authorization.)

2. **WHAT OTHER LIMITATIONS APPLY?** If none, write "none:"_____

3. **PURPOSE:** What is the purpose of the disclosure? (Note – If the disclosure is at the patient's request, simply state "at the patient's request."): Patient's request.

4. **THIS AUTHORIZATION IS VALID UNTIL:**_____ (Note: Unless otherwise stated, I request that this authorization be considered as valid for 12 months from date of signature)

ADDITIONAL TERMS YOU SHOULD KNOW:

1. Not a Condition for Treatment. Refusal to sign this authorization will not affect your ability to receive treatment from the Disclosing Party. 2. Further Uses and Disclosures. Health information to be disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal privacy laws. 3. Right to Revoke. You may revoke this authorization at any time by giving written notice to the Disclosing Party. Your revocation will not be effective to the extent action has already been taken in reliance on your authorization prior to receipt of your written revocation. 4. Photocopies. A photocopy or exact reproduction of this signed authorization will have the same force and effect as the original. 5. Keep a Copy. By signing below, you acknowledge receipt of a copy of this Authorization.

PART III **Send Records to:** Immanuel Lutheran School
2865 – 26th Avenue
Columbus, NE 68601
For Questions Contact: Jody Timm, Principal
Phone: (402) 564-8423 Fax number: (402) 564-1162

_____ _____
Signature of Parent (or Student if 18 years of age or Older) Date

_____
Contact Information (Address & Phone)