

MUST BE COMPLETED, SIGNED AND TURNED IN BEFORE FIRST PRACTICE

SOUTH SIOUX CITY SCHOOL DISTRICT ATHLETIC HEALTH EXAMINATION FORM

Health examination for an athlete must be submitted to the superintendent or principal once each year prior to permitting an athlete to practice or compete in any athletic activity sponsored by the Nebraska School Activities Association certifying that the athlete has been examined and is physically fit for athletic participation for the current school year. The requirement that a physical must be taken once each year means the examination must be given during the school year in which the student participates or during the summer vacation (May 1 or after) that precedes the school year in which the student participates.

Please NOTE: Legislation reversed stances and chiropractors can now administer physicals. MD, DO, PA, APRN and DCs may complete the physical.

Name of Student _____ School _____ Grade _____
Age _____

Significant Past Illness or Injury _____

Height _____ Weight _____ Blood Pressure _____

Eyes _____ R 20/ _____ ; _____ L 20/ _____ Ears _____ Hearing _____ R
_____ /15; L _____ /15

Cardiovascular _____ Neurological _____

Liver _____ Spleen _____ Hernia _____

Skin _____ Genitalia _____

Laboratory: Urinalysis _____ Other: _____

Comments: _____

Completed Immunizations: Polio (date) _____ Tetanus (date) _____
Other _____

"I certify that I am qualified to conduct all phases of the health examination of the above-named student. I further certify that I have on this date examined the student and 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, EXCEPT THOSE CROSSED OUT BELOW."

- | | | | | |
|--------------|----------|--------------|---|------------|
| BASEBALL | FOOTBALL | FIELD HOCKEY | CROSSCOUNTRY | BASKETBALL |
| HOCKEY | GOLF | GYMNASTICS | ROWING | SKATING |
| SKIING | SOCCER | SOFTBALL | SPEEDBALL | SWIMMING |
| TENNIS | TRACK | VOLLEYBALL | * WRESTLING | |
| OTHERS _____ | | | *Estimated Desirable Weight Level _____ | LBS |

Date of Examination _____

Examiner's Signature (MD, DO, PA, APRN, PC) _____

Examiner's Address _____

Telephone _____

STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM This application to compete in interscholastic athletics for the above high school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

Signature of Student _____

"I hereby give my consent for the above-named student (1) to represent his/her school in athletic activities, except those crossed out on this form by the examining health care provider, provided that such activities are approved by the State Association; (2) to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I acknowledge that I have selected the health care provider who has examined the student and assume full responsibility for the selection of such examiner. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such activities or such travel."

Signature of Parent/Guardian _____

Date _____

Address _____

City _____

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SPORTS CANDIDATES' QUESTIONNAIRE (To be completed by parents or family physician)

Name _____ Birth Date _____ Birth Place _____
 Home Address _____ City _____
 Parent's Name _____ Telephone _____

- | | | | |
|-----|--|-----|----|
| 1. | History of diabetes in family | Yes | No |
| 2. | History of epilepsy or other seizure disorders | Yes | No |
| 3. | Has had injuries requiring medical attention | Yes | No |
| 4. | Has had an illness lasting more than a week | Yes | No |
| 5. | Is under a physician's care now | Yes | No |
| 6. | Takes medication now | Yes | No |
| 7. | Wears glasses or
Contact lenses | Yes | No |
| 8. | Has had a surgical operation | Yes | No |
| 9. | Has been in the hospital (except for tonsillectomy) | Yes | No |
| 10. | Do you know of any reason why this individual should
not participate in all sports? | Yes | No |

PLEASE EXPLAIN ANY "YES" ANSWERS TO ABOVE QUESTIONS:

11. Has had complete poliomyelitis immunization by _____ Yes No
 inoculation (Salk) or oral vaccine (Sabin) _____
12. _____ Most recent tetanus toxoid immunization Date

- Was this a booster? _____ Yes No

Parent/Physician Signature

Laboratory Examination: Urinalysis, hemoglobin test, tuberculin test, and chest x-ray are recommended components of the medical appraisal. Other tests will be indicated in some cases. A recent chest x-ray is recommended on the basis of its screening advantage in detecting possible heart problems as well as pulmonary disease.

Immunizations: All athletes should be protected adequately by immunization as locally recommended, especially against tetanus and polio.

Health Examination Form: The following suggested Health Examination Form comprises the medically observable considerations important in evaluating the advisability of an individual's participation in athletics.

Please indicate one of the following:

_____ Our son/daughter is _____ covered by Insurance Co.
 OR
 _____ We will purchase the necessary insurance provided by the school to cover our son/daughter.

Parent/Guardian Signature

PLEASE SIGN

OVER