PRIMERO RE-2 SCHOOL DISTRICT
MEDICAL AUTHORIZATION

Student Name: _____

I hereby represent to Primero RE-2 School District that the student is in good physical health and the trip does not pose a hospital hazard to the student.

I hereby grant permission and give my consent for the above-named student to
(1) Be treated by any qualified nurse, physician or surgeon as may be deemed by Primero School, its agents, servants or employees during the trip;
(2) Be administered medication and/or emergency first aid care as may be necessary or appropriate;
(3) Receive treatment in hospitals, medical offices, clinics or elsewhere in the event of accident or illness.

To assist in the medical care or treatment the medication information herewith supplied on the attached Health Information Form is true and accurate. I will hold the school and its agents, servants and employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of (or the lack of) medical or emergency treatment rendered to the student.

The student, by his/her signature hereto fully agrees and consents to the foregoing.

THE CONDITIONS AND STATEMENTS ON THE REVERSE SIDE ARE AN INTEGRAL PART OF THIS AGREEMENT.

_____
Signature of student Date

_____
Signature of Parent/Guardian Date

HEALTH INFORMATION FORM

Student Name: _____ Parent Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Person who may be contacted in an emergency if parent cannot be located:

Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Health Insurance Co: _____ Policy Number: _____

1. Please list any significant health problems this student has of which sponsors should be aware:
   _____
2. Does this student have any drug allergies? _____
3. Please list all medications that this student is taking now and/or will take along on the trip:
   _____

WARNING TO STUDENTS AND PARENTS
PERTAINING TO PARTICIPATION

SERIOUS, CATASTROPHIC AND PERHAPS FATAL INJURY MAY RESULT FROM ATHLETIC PARTICIPATION

By its very nature, competitive athletics may put students in situations in which SERIOUS, CATASTOPHIC, and perhaps FATAL ACCIDENTS may occur.

Many forms of athletic competition result in violent physical contact among players, the use of equipment which may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury.

Students and parents must assess the risks involved in such participation and make their choice to participate in spine of those risks. No amount of instruction, precaution or supervision will totally eliminate all risk of injury. Just as driving an automobile involves choice of risk; athletic participation by high school students also may be inherently dangerous. The obligation of students and parents in making this choice to participate cannot be overstated. There have been accidents resulting in death, paraplegia, and other very serious permanent physical impairment as a result of athletic competition.

By granting permission for your student to participate in athletic competition, you, the parent or guardian, acknowledge that such risks exist.

By choosing to participate, you, the student acknowledge that such risks exist.

Students will be instructed in proper utilization of all equipment worn or used in practice and competition. Students must refrain from improper uses and techniques.

As previously stated, no amount of instruction, precaution, and supervision will totally eliminated all risk of serious, catastrophic or even fatal injury.

If any of the foregoing is not completely understood, please contact your school principal for further instruction.

Student's Name: _____

Sport(s) _____

This acknowledges that we have read and understand the material contained in the NOTICE TO ATHLETES AND PARENTS OR GUARDIANS.

_____

Parent signature Date

_____

Student signature Date

INSURANCE STATEMENT

To whom it may concern:

_____ _____ is not insured by parents

Student's Name

_____ is insured for health and accident by _____ insurance company and may participate in athletics at Primero High School.

It is understood that the school district insurance company shall be considered secondary insurance if the student is covered by the parents insurance. If the student is not covered by the parents insurance the school insurance shall be the primary insurance.

_____ _____

Date Signature of Parent/Guardian

MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

MEDICAL HISTORY OF STUDENT AND FAMILY		YES	NO	MEDICAL HISTORY OF STUDENTS AND FAMILY		YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?			32.	Do you have any rashes, pressure sores, or other skin problems?		
2.	Do you have an ongoing medical condition (like diabetes or asthma)?			33.	Have you ever had herpes skin infection?		
3.	Are you currently taking any prescription or non-prescription (over the counter) medications or pills?			34.	Have you ever had a head injury or concussion?		
4.	Do you have allergies to medicines, pollens, foods or stinging insects?			35.	Date or last head injury or concussion: _____		
5.	Do you have prescription for use of epinephrine, adrenalin, inhaler, or other allergy medications?			36.	Have you ever been hit in the head and been confused or lost your memory?		
6.	Have you ever passed out or nearly passed out during or after exercise?			37.	Have you ever been knocked unconscious?		
7.	Have you ever passed out or nearly passed out any other time?			38.	Have you ever had a seizure?		
8.	Have you ever had discomfort, pain or pressure in your chest during exercise?			39.	Do you have headaches with exercise?		
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?			40.	Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
10.	Does your heart race or skip beats during exercise?			41.	Have you ever been unable to move your arms or legs after being hit or falling?		
11.	Has a doctor ever told you that you have (check all that apply) ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection			42.	When exercising in heat, do you have severe muscle cramps or become ill?		
				43.	Has a doctor ever told you that you or someone in your family has sickle cell trait or sickle cell disease?		
12.	Has a doctor ever ordered a test for your heart?			44.	Have you had any other blood disorders or anemia?		
13.	Has anyone in your family died suddenly for no apparent reason?			45.	Have you had any problems with your eyes or vision?		
14.	Does anyone in your family have a heart problem?			46.	Do you wear glasses or contact lenses?		
15.	Has any family member or relative died of heart problems or sudden death before age 50?			47.	Do you wear protective eyewear, such as goggles or a face shield?		
16.	Does anyone in your family have Marfan syndrome?			48.	Are you happy with your weight?		
17.	Have you ever spend the night in a hospital			49.	Are you trying to gain or lose weight?		
18.	Have you ever had surgery?			50.	Do you limit or carefully control what you eat?		
19.	Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis that caused you to miss practice or a game?			51.	Has anyone recommended you change your weight or eating habits?		
				52.	Do you have any concerns that you would like to discuss with a doctor.		
20.	Have you had any broken or fractured bones or dislocated joints?			53.	What is the date of your last Tetanus immunization? Date:_____		
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?				FEMALES ONLY		
22.	Have you ever had a stress fracture?			54.	Have you ever had a menstrual period?		
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR have you ever been told that you have that disorder or any neck/spine problems?			55.	Age when you had your first menstrual period? _____		
24.	Do you regularly use a brace or assistive device?			56.	How many periods have you had in the last 12 months? _____		
25.	Have you ever been diagnosed with asthma or other allergic disorders?			57.	Do you take a calcium supplement?		
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?				Explain "Yes" answers here:		
27.	Is there anyone in your family who has asthma?						
28.	Have you ever used an inhaler or taken asthma medicine?						
29.	Were you born without or are missing a kidney, an eye, a testicle, or any other organ?						
30.	Have you had infectious mononucleosis (mono) within the last three months?						
31.	Have you ever had mono or any illness lasting more than two weeks?						

Parent/Guardian Signature: _____ Athlete's Signature: _____

PHYSICAL EXAMINATION

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____ BP: _____

*Percent Body Fat: _____

*Audiogram: _____

*Vision: Corrected: (L) _____ (R) _____

Uncorrected: (L) _____ (R) _____

Pulse: *(rest): _____
*(Exercise): _____
*(Recovery): _____
*FEV or Peak
Flow (rest): _____
*(Exercise): _____
*(Recovery): _____

	N	Abnormal		N	Abnormal
Eyes			Cervical spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and/or Iron stores		
Peripheral pulses			Λ Echocardiogram		
Abdomen			Λ Neuropsyc Testing		
Genitalia/hernia (male only)			Λ Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

Λ WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decisions)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

____ CLEARED WITHOUT RESTRICTIONS
____ Cleared **AFTER** further evaluation or treatment for: _____
____ Cleared for **Limited Participation** (check and explain "reason" for all that apply):
- Not cleared for (specific sports): _____
- Cleared only for (specific sports): _____

____ **NOT CLEARED FOR PARTICIPATION: _____**
Reason(s): _____
____Other recommendations: _____
- Recommend monitoring during early conditioning because of weight/fitness/other
- Recommend restrictions or monitoring of weight loss or gain
- Other: Reasons: _____

MD/DO, PA, NO, DE-SPC#, Signature: _____

Date of examination: _____ Date signed: _____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print)

_____

Address: _____ City: _____ State: _____ Zip: _____