Southern Columbia Area School District

Southern Columbia High School

812 Southern Drive
Catawissa, PA 17820

570-356-2331 or 672-2983
Fax 570-356-2835

School Sports Examination

Dear Parent:

We are beginning to schedule with the school physicians the sports participation examinations (the "Sports Examination"). Please review the Information and Guidelines for School Physical Examinations enclosed herewith and then **complete, sign, date and return this form to the school nurse by** _____.

☐ I will have my student's Sports Examination completed by my family physician and return the signed PIAA card to the school nurse by _____ prior to the first practice.

OR

☐ I consent to have my student's Sports Examination performed by a school physician and understand that it will include a review of immunization records, a confidential health history interview and a physical assessment which may, at the discretion of the health care provider, include:

- head, eyes, ears, nose, mouth, throat
- neck, chest, lungs
- abdomen
- spine/scoliosis (bending position)
- external genitalia
- musculoskeletal system
- cardiovascular system, blood pressure
- skin

Please note that your student's Sports Examination must be completed and the signed PIAA card returned to the school nurse before your student will be allowed to participate in practice.

Student Name: _____ **Sport:** _____

Parent Signature: _____ **Date:** _____

Thank you,

Jean Atherton, RN

Paul R. Caputo, Principal
pcaputo@scolumbiasd.k12.pa.us

Dr. Alan J. Lonoconus, Superintendent
lono@scolumbiasd.k12.pa.us

SCREENING QUESTIONS FOR ATHLETIC PHYSICAL EXAMINATION

Name: _____ Age: _____ Grade: _____

First Date of Participation: _____ Athletic Event: _____

List any serious illness since last physical: _____

_____

_____

	Yes	No
1. Has any member of your family had a "heart attack" or "heart condition" prior to the age of 50.		
2. Do you have to stop while running around a quarter mile track twice?		
3. Are you taking any medication?		
4. Have you ever "passed out" or been "knocked out"?		
5. Have you ever had any illness, condition or injury that: **A. Required you to go to the hospital as a patient overnight or to the emergency room for x-rays?**		
B. Required an operation?		
C. Caused you to miss a game or more than one practice?		

Please give details to any "Yes" answer:

_____

_____

_____

DATE	SPORT	VITAL SIGNS	COMMENTS	Doctor's Signature
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.
				M.D.

SOUTHERN COLUMBIA ATHLETIC TRAINING ROOM MEDICAL INFORMATION SHEET

Name: _____ Age: _____ Date of Birth:_____

Parent/Guardian's Names: _____

Sport(s) 1. _____ **Sex:** M / F
2. _____ **Grade:** 7 8 9
3. _____ 10 11 12

Home Address: _____ Home Phone #_____
_____

Parent/Guardian's Address (If Different):_____
Parent/Guardian's Home Phone (If Different):_____

IN CASE OF EMERGENCY:

DAYTIME- Name: _____ Relationship: _____
Phone Number: _____
EVENING- Name: _____ Relationship: _____
Phone Number: _____

IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ Relationship: _____
Phone Number: _____

FAMILY PHYSICIAN

Name: _____ Phone Number:_____
Hospital Preference: _____ School Insurance: Yes No
Medical Insurance Company: _____

GENERAL MEDICAL INFORMATION

Has your child ever had, or does now have any of the following?

	Yes	**No**	**Please Explain all "Yes" responses**
Asthma	____	____	_____
Diabetes	____	____	_____
Heart Problems	____	____	_____
Allergies	____	____	_____
High Blood Pressure	____	____	_____
Head Injury	____	____	_____
Seizure Disorder	____	____	_____
Other	____	____	_____

Has your child been hospitalized, or had significant surgery? Yes No
Please Explain _____
_____

Is your child taking any medications regularly? Yes No
Please Explain_____

ORTHOPEDIC INJURIES

Has your child ever had, or now have, any injury to any of the following Please note which side this injury occurred to:

	Yes	No	Explain
Neck……..	____	____	_____
Shoulder……	____	____	_____
Arm/Elbow……	____	____	_____
Wrist……..	____	____	_____
Hand/Fingers…….	____	____	_____
Back……...	____	____	_____
Ribs……	____	____	_____
Spine……..	____	____	_____
Hip/Groin/Thigh….	____	____	_____
Knee……	____	____	_____
Lower leg……	____	____	_____
Ankle……..	____	____	_____
Foot…….	____	____	_____
Other……...	____	____	_____

Any other health problems that would be helpful in the treatment of your child?
_____

The above responses are true to the best of my knowledge

_____
Signature of Parent/Guardian

I give my permission for my son/daughter to be treated by the athletic training staff at Southern Columbia. In the event of an emergency, I give my permission for my son/daughter to be treated at a hospital if necessary

_____
Signature of Parent/Guardian

PERMISSION TO PARTICIPATE

THIS PORTION MUST BE RETURNED TO THE COACH BEFORE THE STUDENT IS ALLOWED TO PARTICIPATE IN PRACTICE OR EVENTS!!!

Name of Athlete _____

List sport in which you wish to participate _____

School term (Date): _____

Insurance information:

1. Do you have school insurance? Yes_____ No_____
2. Name of family insurance company _____
3. Policy number _____

Permission to participate:

I give permission for my son/daughter to participate in the sport(s) listed above at Southern Columbia High School

_____
Signature of Parent or Guardian

PERMISSION FOR TREATMENT:

In the event of an emergency, I give my permission for my son/daughter to be treated by the physician in attendance or at a hospital or dispensary if necessary.

_____
Signature of Parent or Guardian

I have read and understand the guidelines for participation in interscholastic athletics as stated in this booklet.

_____
Signature of Parent or Guardian

Information & Guidelines for School Medical Examinations

The Pennsylvania Public School Code mandates that the school district physician make a medical examination and a comprehensive appraisal of die health of every child of school age (I) upon original entry into school in die Commonwealth, (2) while in the sixth grade, and (3) while in the eleventh grade. PIAA requires medical examination prior to student participation in interscholastic athletics. The School Code requires that every school physician be assisted by a school nurse who shall be present during each examination.

In lieu of medical examinations required to be performed by the school physician, any child of school age may furnish school district officials with a medical report of examination made at his or her own expense by his or her family physician on an approved form. Copies of this form are available at the nurses' office in each school. As the family physician knows your student best, parents are encouraged to have the required medical examinations performed by the family physician. Medical examinations by the school physician will be scheduled and provided for students who do not submit medical reports from their family physician.

Medical examinations by the school physician shall be conducted in rooms identified and equipped for this purpose. The school physician shall require the removal of sufficient clothing to insure complete examination. Parents or guardians will be advised in advance of the date of examination and encouraged to be present. School medical examinations will be made in the presence of the parent or guardian when so requested.

The medical examination shall include:

1. Confidential health history and interview of the student, which may include at the discretion of the health care provider:
    - Past medical history
    - Developmental history
    - Family and social history
    - Review of systems
2. Physical assessment, which may include the following at the discretion of the health care provider:
    - Head, eyes, ears,, nose, mouth, throat
    - Neck, chest, lungs
    - Abdomen
    - Spine/scoliosis (bending position)
    - External genitalia
    - Musculoskeletal system
    - Cardiovascular system, blood pressure
    - Skin
3. Review of immunization records

Any recommendation as to medical care shall be sent to each parent or guardian on appropriate forms with instructions to the parent or guardian to consult their family physician as needed and to notify the school authorities of die action taken with respect to the recommendations.

The school nurse will maintain a medical and immunization history and an individual health record for each student Health records shall be confidential and their contents shall be divulged only when necessary for the health of the child or at the request of the parent or guardian to a qualified practicing physician. Upon the transfer of the child to another district, the district shall, upon request of the receiving district surrender the health record of the student to that district.

The periodic medical examination will be a health appraisal as well as serve as a learning experience for the student in an effort to promote responsible and healthy living habits. Parents are encouraged to be present for medical examinations. If you have any questions or concerns, please call die school nurse prior to die examination date.