



## CONSENT TO TREAT AND EMERGENCY CONTACT INFORMATION FORM

**SPORT:** \_\_\_\_\_

**LAST NAME:** \_\_\_\_\_

**FIRST NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_

**ZIP CODE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**YEAR:** \_\_\_\_\_

Fr.

So.

Jr.

Sr.

**TELEPHONE:** \_\_\_\_\_

**HOME:** \_\_\_\_\_

**CELL:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_

**RELATION:** \_\_\_\_\_

**EMERGENCY CONTACT NUMBER:** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN (IF APPLICABLE):** \_\_\_\_\_

**ORTHOPEDIC PHYSICIAN (IF APPLICABLE):** \_\_\_\_\_

**INSURANCE NAME:** \_\_\_\_\_

**EXPIRATION DATE:** \_\_\_\_\_

**PLEASE LIST ANY SIGNIFICANT INJURIES, ALLERGIES, AND DATES OF SURGERY:**

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I freely and voluntarily assume all risks of participation in school-approved athletics/activities. I also give consent to have Athletico athletic trainers, physical therapists, massage therapists or other affiliated qualified medical personnel to provide me with medical assistance and/or treatment and agree to save and hold harmless and indemnify each and all Athletico personnel from all liability, loss, cost, or other claim of damage whatsoever, including, injury, death or damage to property.

If participant is under the age of 18, waiver must also have parent or legal guardian signature.

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**PLAYER/PARENT SIGNATURE**

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**DATE**



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of \_\_\_\_\_

- Medically eligible for certain sports \_\_\_\_\_

- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).  
\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).  
\_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		Yes	No
(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			
1. Do you have any concerns that you would like to discuss with your provider?			
2. Has a provider ever denied or restricted your participation in sports for any reason?			
3. Do you have any ongoing medical issues or recent illness?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?			
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			
7. Has a doctor ever told you that you have any heart problems?			
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.			

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS		Yes	No
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS		Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

<b>MEDICAL QUESTIONS (CONTINUED)</b>		<b>Yes</b>	<b>No</b>
25. Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods or food groups?			
28. Have you ever had an eating disorder?			
<b>FEMALES ONLY</b>		<b>Yes</b>	<b>No</b>
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

## Explain “Yes” answers here.

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete:

Signature of parent or guardian:

Date: \_\_\_\_\_

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## ■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION			
Height:	Weight:		
BP: _____ / _____ (    /    )	Pulse: _____ Vision: R 20/ _____ L 20/ _____		
Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N			
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance			
<ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>			
Eyes, ears, nose, and throat			
<ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>			
Lymph nodes			
Heart <sup>a</sup>			
<ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>			
Lungs			
Abdomen			
Skin			
<ul style="list-style-type: none"> <li>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>			
Neurological			
MUSCULOSKELETAL		NORMAL	ABNORMAL FINDINGS
Neck			
Back			
Shoulder and arm			
Elbow and forearm			
Wrist, hand, and fingers			
Hip and thigh			
Knee			
Leg and ankle			
Foot and toes			
Functional			
<ul style="list-style-type: none"> <li>• Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>			

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA



## IHSA Sports Medicine Acknowledgement & Consent Form

### Acknowledgement and Consent

#### **Student/Parent Consent and Acknowledgements**

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Substance Policy.

#### **STUDENT**

Student Name (Print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **PARENT or LEGAL GUARDIAN**

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

#### **Consent to Self Administer Asthma Medication**

Illinois Public Act 098-0795 provides new directions for schools concerning the self-carry and self-administration of asthma medication by students. In order for students to carry and self-administer asthma medication, parents or guardians must provide schools with the following:

- Written authorization from a student's parents or guardians to allow the student to self-carry and self-administer the medication.
- The prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

A full copy of the law can be found at <http://www.ilga.gov/legislation/publicacts/98/PDF/098-0795.pdf>.