# Benzie Central High School

# Athletic Packet

# Benzie Central Athletics

Dear Parent(s) and Athlete,

Welcome to the 2020/2021 Benzie Central Sports season! We are delighted that you are joining us and we want to help you be successful in completing the necessary documents for participation. This packet will give you the necessary forms needed by your coach, athletic trainer, school administration and MHSAA. Please make sure that all forms and payment are completed prior to submitting to your coach. It is very important that all information is provided. Please notice that many forms, including the Athletic Release form requires both a parent and athlete signature.

Thank you,

Benzie Central Athletic Department

## Important Information

- Sports Physical must be dated by physician on or after April 15, 2020, to be valid for the 2020/2021 school year or fill out a MHSAA Health Questionnaire if you had a Sports Physical for the 2019/2020 school year.
- Pay to Participate fees (to Athletic Office)
    - HS Participation Fees: $35/sport or $100 max/school year
    - MS Participation Fees: $25/sport or $70 max/school year
    - Families-MS or HS: $200 max for the school year

For all questions and payment for both Pay to Participate and Athletic Sports Passes, please see Mrs. Grose in the Athletic Office. All checks can be made to Benzie Central High School (BCHS)

**Benzie Central Athletic Department**

**Student Athlete Emergency Information Form**

Parents and/or Guardians:

The following is a permission form that must be completed and signed by you and your student athlete before they may participate in an interscholastic athletic event for Benzie Central Schools. In signing this letter you should be aware of the following important points:

1. Benzie Central Schools **DOES NOT** provide an insurance program covering health or injury problems resulting from athletics. It is the responsibility of the athlete and their family to provide such insurance and to take care of any medical expenses.
2. In signing this form you are giving your student athlete permission to travel under the coach's direction and authority to and from athletic events.
3. The coaches shall have the authority to seek medical attention in case of injury in any athletic gathering (practice, contests or authorized team activity).

Athlete Name:_____

Birthdate:_____ Grade:_____ Gender: Male Female

Address:_____

City:_____ Zip:_____

Parent/Guardian Name:_____

Phone (home/cell):_____ Work (mom/dad):_____

**IF AN EMERGENCY SHOULD OCCUR AND PARENTS CANNOT BE REACHED, THE FOLLOWING INDIVIDUALS WILL BE CALLED:**

Emergency #1:_____ Phone:_____

Emergency #2:_____ Phone:_____

Physician:_____ Phone:_____

Hospital Choice:_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow their instructions. If the physician cannot be reached, the school may make whatever arrangements deemed necessary for the well-being of the child. I understand medical information may be provided to the Athletic Department for my child to participate in interscholastic athletics. This information will be treated with full confidentiality by this department.

Athlete Signature:_____ Date:_____

Parent Signature:_____ Date:_____

**MEDICAL HISTORY**

Indicate any issues we need to be aware of for the health and well-being of your student.

ALLERGIES:_____ ASTHMA:_____

SEIZURES:_____ DIABETES:_____

CARDIAC:_____ SURGERIES:_____

CURRENT MEDICATIONS:_____

**Athletic Release Form**

Athlete's Name:_____

Grade:_____ Sport(s) Participating in this school year:_____

Parents/Guardians Name:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Home Address:_____

Mailing Address:_____

City:_____Zip:_____

Email (parents):_____

Email (students):_____

By signing this form, you are indicating that you have read, understand and will support the rules, policies and procedures of the Benzie County Central Schools.

You are also acknowledging the fact that you understand athletics have an inherent risk involved while participating in sports. The coaches and staff are trained to maintain your athlete's safety as their most important priority, but you must also remind your athlete they need to follow the directions given by the coaching staff.

Understand at times, the media and other educational institutions request information about your athlete and their athletic activities, you understand we will provide only the following items: name, grade, individual and/or team pictures, game statistics, and annual awards, other information will only be supplied with proper releases from the counseling office and principal's office.

I hereby give my consent for my athlete (name) _____ to engage in interscholastic athletics and for the disclosure of the MHSAA of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics: and I understand the possibility that serious injury may result from participating in athletic activities. My athlete has my permission to accompany the team as a member on its out-of-town trips. I further understand that my son/daughter will be expected to adhere firmly to all established athletic policies of Benzie County Central Schools and the Michigan High School Athletic Association.

_____ _____

Student/athlete Signature Parent/guardian Signature

_____ _____

Date Date

# PARENT & ATHLETE CONCUSSION INFORMATION SHEET

HEADS UP CONCUSSION

## WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

## DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

## SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

## SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[ INSERT YOUR LOGO ]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

_____

STUDENT-ATHLETE NAME PRINTED

_____

STUDENT-ATHLETE NAME SIGNED

_____

DATE

_____

PARENT OR GUARDIAN NAME PRINTED

_____

PARENT OR GUARDIAN NAME SIGNED

_____

DATE

MUNSON HEALTHCARE
Paul Oliver Memorial Hospital

## Concussion Information Sheet for Athletes, Parents or Legal Guardians

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. The concussion may or may not cause you to black out or pass out. It can happen from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have after a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for the following symptoms:

| Thinking | Physical | Emotional/Mood | Sleep |
|---|---|---|---|
| • Difficulty thinking clearly<br>• Taking longer to figure things out<br>• Difficulty concentrating<br>• Difficulty remembering new information | • Headache<br>• Fuzzy or blurry vision<br>• Feeling sick to your stomach/queasy<br>• Vomiting/throwing up<br>• Dizziness<br>• Balance problems<br>• Sensitivity to noise or light | • Irritability-things bother you more easily<br>• Sadness<br>• Being more moody<br>• Feeling nervous or worried<br>• Crying more | • Sleeping more than usual<br>• Sleeping less than usual<br>• Trouble falling asleep<br>• Feeling tired |

Table is adapted from the Centers for Disease Control and Prevention (http://cdc.gov/concussions/).

**What should I do if I think I have a concussion?** If you are having any of the signs and symptoms listed above, you should tell your parents, coach, athletic trainer, or school nurse, so you can get the help you need. If a parent notices these symptoms, he or she should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny or slurred, let an adult such as your parent, coach, or teacher know right away, so you can get the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early after a concussion, you may have long-term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any available medical personnel that you think you have a concussion. According to the Benzie Central and POMH Concussion policy, you must follow the concussion management flow sheet and appropriate return to sport protocol administered by a trained appropriate medical profession (Athletic Trainer or Physical Therapist). Then be referred to a physician to be cleared by them. **You CAN NOT return to play or practice on the same day as your suspected concussion occurred due to MHSAA rules. You must have the official MHSAA unconditional return to sport form in order to return.**

**You should not begin the return-to-play progression, until all symptoms are gone, both at rest and during and after activity, unless allowed to by Certified Athletic Trainer or other trainer**

**professional. Symptoms indicate that your brain has not yet recovered from the concussion and needs more rest.**

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Athlete Name:

_____

*This form must be completed by every athlete, even if there are multiple athletes in the household.*

Parent or Legal Guardian Name(s):

_____

*Review and sign even if athlete is 18 or older*

☐ We have read the "Athlete and Parent or Legal Guardian Concussion Information Sheet
*If true, please check box*

| **Athlete Initials** | After reading the information sheet, I am aware of the following information: | **Parent or legal guardian Initials** |
|---|---|---|
| _____ | A concussion is a brain injury, which should be reported to my parents, my coach(es), or athletic trainer. | |
| | A concussion can affect the ability to perform everyday activities such as ability to think, balance, and perform in the classroom. | |
| | A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury. | |
| _____ | I will tell my parents, my coach, or athletic trainer about my injuries and illnesses. | Not Applicable |
| _____ | If I think a teammate has a concussion, I should tell my coach(es), parents or athletic trainer. | Not Applicable |
| _____ | I will not return to play in a game or practice if a hit to my head or body causes any concussion related symptoms. | Not Applicable |
| _____ | I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion, an athletic trainer then a doctor. | _____ |
| | According to the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than 1 medical evaluation. | |
| _____ | I realize that emergency department or urgent care physicians will not provide clearance if the patient is seen right away after the injury. | _____ |
| _____ | After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury, even death, if return to play or practice occurs before concussion symptoms go away. | _____ |
| | Sometimes, repeat concussions can cause serious and long-lasting problems. | |

**I have read and understand the concussion symptoms on the Concussion Information Sheet.**

_____ _____

Signature of athlete Date

_____ _____

Signature of Parent or Legal Guardian Date

Consent for Medical Treatment

MUNSON HEALTHCARE

Benzie Central High School-Athletic Training

I,_____, an 18-year old or Parent or legal guardian of _____, born_____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. The emergency medical care initially, will be provided by a Certified Athletic Trainer or Board Certified Sports Clinical Specialist in Physical Therapy (SCS). I do herby consent in advance to such emergency care, including hospital care, as deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Student's Name:_____Gender:_____Grade:_____

Emergency Contact 1 Name:_____

Cell:_____ Work:_____ Relation:_____

Emergency Contact 2 Name:_____

Cell:_____ Work:_____ Relation:_____

_____ Date:_____

Signature of Parent or Guardian or 18 year-old

MUNSON HEALTHCARE

FORM #2397 (04/17)

# AUTHORIZATION TO CONTACT, INTERVIEW, PHOTOGRAPH, RECORD, OR RELEASE PROTECTED HEALTH INFORMATION FOR PROMOTIONAL/EDUCATIONAL PURPOSES

Information about you and your health is personal, and Munson Healthcare is committed to protecting the privacy of that information. When we want to share your information for the public to see or hear, we must ask you for written permission (authorization). You can ask to stop an interview or recording session at any time.

**Please read this form carefully and ask any questions you have before signing it.**

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I, (PRINT NAME) _____ **authorize Munson Healthcare and/or its affiliates and service organizations to contact, interview, take audio/photography/video of me, and to use and/or share information about me for promotional and/or educational purposes on behalf of Munson Healthcare, including:**

- Advertisements, brochures, electronic communications, multimedia productions, publications, social media, web sites, etc., directed to staff, physicians, volunteers, patients, visitors, and the general public
- Local or national news media coverage

**Information about me to be used and/or shared includes:**

☐ My appearance/likeness on recorded or electronic media *(e.g. interview notes, audio, photographs, video, etc.)* and information about my diagnosis and treatment gathered though interviews with me by Munson Healthcare staff or the news media

☐ Information, including Protected Health Information, gathered through interviews with health care providers and others involved in my care *(e.g. physicians, nurses, technicians, staff, etc.)*

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I understand that signing or refusing to sign this authorization will not affect the delivery of care in any way.

I understand that this authorization does not include any promise to pay me and that Munson Healthcare will not receive payment of any kind for the use of information/material covered by this authorization.

I understand that information/material covered by this authorization may be used at any time, with no expiration date.

After signing this authorization, I understand I may change my mind and revoke this authorization in writing, except to the extent of action already taken based on this authorization. Once information/material is used and/or shared as allowed by this authorization, it is no longer protected under federal and state privacy laws and may be subject to re-disclosure.

I release and forever discharge Munson Healthcare and its agents, from any claims and demands in connection with the use of information/material covered by this authorization, including, but not limited to, any claims for invasion of privacy or defamation.

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SIGNATURE (INDIVIDUAL OR RESPONSIBLE REPRESENTATIVE): _____

NAME OF RESPONSIBLE REPRESENTATIVE (if applicable): _____ RELATIONSHIP TO INDIVIDUAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

SIGNATURE (WITNESS/ORG. REPRESENTATIVE): _____

NAME (WITNESS/ORG. REPRESENTATIVE): _____ DATE: _____ TIME: _____

---

**INTERNAL USE:**

TOPIC: _____

_____

_____

ORGANIZATION:

☐ Kalkaska Memorial Health Center
☐ Mackinac Straits Health System
☐ Munson Healthcare Cadillac Hospital
☐ Munson Healthcare Charlevoix Hospital
☐ Munson Healthcare Grayling Hospital
☐ Munson Healthcare Home Health
☐ Munson Healthcare Manistee Hospital
☐ Paul Oliver Memorial Hospital
☐ Munson Medical Center
☐ North Flight EMS
☐ Otsego Memorial Hospital
☐ Other MHC Affiliate (Please Specify) _____

## NOTICE AND WAIVER TO ALL VOLUNTARY ACTIVITY PARTICIPANTS

**(MINOR)**

I agree that _____**(MINOR)** has my permission to participate in **activities** which will take place at **Benzie Central** during the 2020-2021 school year. Student and parent/guardian have read and agree to follow **Benzie Central's** participation rules.

I agree that participation in the above noted activity is voluntary and I have knowledge of and assume all risks for the activity to include injuries as well as exposure to communicable diseases, including COVID19.

I certify that I understand current COVID19 risks and symptoms and current CDC guidelines. I certify that **MINOR** has not had any symptoms of COVID19/coronavirus nor been exposed to anyone that had such symptoms or diagnosis in the last 14 days. I agree to notify Benzie Central of any changes and I will NOT send **MINOR** to the activity if any symptoms develop or with notice of an exposure to COVID19 until the **MINOR** has been medically cleared.

I understand that this discharges **Benzie Central, ITS EMPLOYEES**, and **AGENTS** from any liability or claim. **Benzie Central, ITS EMPLOYEES, AND AGENTS** will not assume responsibility for any injury or illness incurred while participating or attending the program or any physically related activity. Certain risks are inherent during participation in these events. Nor will Benzie Central or its employees or agents be liable for lost or stolen items while participants are using the facilities or are on the premises. I waive all claims and release Benzie Central and its **EMPLOYEES** and **AGENTS** from any and all injury, illness, or damage that **MINOR** or **I** may suffer as a result of participation or attendance in the activity. I agree to indemnify and hold Benzie Central, **ITS EMPLOYEES**, and **AGENTS** harmless from any claims presented on **MY OWN BEHALF**, or claims presented by **MINOR** or **MINOR's representative.**

Signature of Parent or Guardian _____ Date _____

**(ADULT)**

I agree to participate in **activities** which will take place at **Benzie Central** during the dates 2020-2021 school year. I have read and agree to follow **Benzie Central's** participation rules.

I agree that participation in the above noted activity is voluntary, and I have knowledge of and assume all risks for the activity to include injuries as well as exposure to communicable disease, including COVID19.

I certify that I understand current COVID19 risks and symptoms and current CDC guidelines. I certify that I have not had any symptoms of a COVID19/coronavirus nor been exposed to anyone who has had such symptoms or diagnosis in the last 14 days. I agree to notify Benzie Central of any changes and I will NOT participate if any symptoms develop or with notice of an exposure to COVID19 until medically cleared.

I understand that this discharges the **Benzie Central, ITS EMPLOYEES**, and **AGENTS** from any liability or claim. **Benzie Central, ITS EMPLOYEES, AND AGENTS** will not assume responsibility for any injury or illness incurred while participating in the program or any physically related activity. Certain risks are inherent during participation in these events. Nor will Benzie Central or its employees or agents be liable for lost or stolen items while participants are using the facilities or are on the premises. I release and waive all claims against Benzie Central and its **EMPLOYEES** and **AGENTS** from any and all injuries or damages I may suffer as a result of my participation in the activity. I agree to indemnify and hold the **Benzie Central, ITS EMPLOYEES**, and **AGENTS** harmless from any claims.

Signature _____ Date _____

## Parent-Player Pre-Workout Screening Agreement
## Benzie Central Schools

To comply with the MHSAA and State of Michigan protocols, we need to verify the health of our student-athletes prior to their participation in athletic activities. As your student-athlete's parent and/or guardian, your permission for them to attend and participate is required.

At each activity where a coach is present there will be a list of participants from Benzie Schools. Coaches will record each attending participant noting they are in compliance with the MHSAA and State of Michigan guidelines for health and safety. When the student–athlete checks in with their coach, the coach will verify that the student-athlete understands and meets the criteria listed below. The coach will also verify the following:

**To ensure the safety of our players, staff members and others in attendance, your child may not attend or participate in any event if the answer is "yes" to any of the following questions.**

- Does the player have a fever?
- Does the player have a cough?
- Does the player have a sore throat?
- Does the player have shortness of breath?
- Has the player had close contact or cared for someone that has COVID-19?
- Is the player's temperature higher than 100.3 degrees?

To further ensure that we are promoting the safest possible environment, the following safeguards are in place:

- All coaches or other adults helping players are also screened for signs/symptoms of COVID-19 prior to each workout session. Screening includes a temperature check.
- An attendance and "no" response for each child will be recorded at each event and stored and must be made available upon request (either by the coaching staff, Benzie Central Schools, and/or the MHSAA).
- Any person with positive symptoms reported will not be allowed to take part in workouts and should contact his or her primary care provider or other appropriate health care professional.
- Vulnerable individuals should not oversee or participate in any workouts.

*By signing my name below, as the parent or guardian of the student-athlete listed below, I agree that:

- My student-athlete will not attend any activity if the answer to any of the questions listed in the box above is "yes".
- My student-athletes attendance will be noted, verified, and also recorded as a "no" to each of the questions and they may participate in the activity related to the sport(s) identified below.
- I (as the parent/guardian) am the primary person responsible for conducting and documenting the MHSAA's Pre-Workout Screening.
- My student-athlete will be participating in activities where they could be at risk of exposure to an air-born or skin infection and/or virus. I waive the schools liability and understand these risks.

| Player's Printed Name | Player's signature | Date |
|---|---|---|
| Parent/guardian Printed Name | Parent/guardian signature | Date |

Please circle the specific sporting activities that your student-athlete may attend:

☐ Basketball ☐ Football ☐ Volleyball ☐ Cross Country ☐ Track ☐ Cheerleading

☐ Soccer ☐ Golf ☐ Baseball ☐ Softball ☐ Skiing ☐ Bowling

*Note: A player will not be allowed to attend or participate in any activity without having this document signed.

# MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

MHSAA michigan high school athletic association

Student Name: _____ Date of Birth: _____

Doctor: _____ Doctor's Phone: _____ Date of Exam: _____

| | | | | | |
|---|---|---|---|---|---|
| | Has a doctor ever denied or restricted your participation in sports for any reason? | | | Do you cough, wheeze or have difficulty breathing during or after exercise? | |
| | Do you have any ongoing medical conditions? If so, please identify below: | | | Have you ever used an inhaler or taken asthma medicine? | |
| | ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other: | | | Is there anyone in your family who has asthma? | |
| | Have you ever spent the night in the hospital or have you ever had surgery? | | | Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ? | |
| | | | | Do you have groin pain or a painful bulge or hernia in the groin area? | |
| | Have you ever passed out or nearly passed out DURING or AFTER exercise? | | | Have you had infectious mononucleosis (mono) within the last month? | |
| | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | | Do you have any rashes, pressure sores or other skin problems? | |
| | Does your heart ever race or skip beats (irregular beats) during exercise? | | | Have you had a herpes or MRSA skin infection? | |
| | Has a doctor ever told you that you have any heart problems? Check all that apply: | | | Do you have headaches or get frequent muscle cramps when exercising? | |
| | ❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol | | | Have you ever become ill while exercising in the heat? | |
| | ❑ Kawasaki disease ❑ Other: | | | Do you or someone in your family have sickle cell trait or disease? | |
| | Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram) | | | Have you had any problems with your eyes or vision or any eye injuries? | |
| | Do you get lightheaded or feel more short of breath than expected during exercise? | | | Do you wear glasses or contact lenses? | |
| | Do you have a history of seizure disorder or had an unexplained seizure? | | | Do you wear protective eyewear such as goggles or a face shield? | |
| | Do you get more tired or short of breath more quickly than your friends during exercise? | | | Immunization History: Are you missing any recommended vaccines? | |
| | | | | Do you have any allergies? | |
| | Has anyone in your family had unexplained fainting, unexplained seizures or near drowning? | | | Have you ever had a head injury or concussion? | |
| | Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? | | | Do you have any concerns that you would like to discuss with a doctor? | |
| | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)? | | | Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems? | |
| | Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia? | | | Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling? | |
| | | | | Have you ever had an eating disorder? | |
| | Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game? | | | Do you worry about your weight? | |
| | Have you ever had any broken or fractured bones, dislocated joints or stress fracture? | | | Are you trying to or has anyone recommend that yo n or lose weight? | |
| | Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches? | | | Are you on a special diet or do you avoid certain types of foods? | |
| | Do you regularly use a brace, orthotics or other assistive device? | | | | |
| | Do you have a bone, muscle or joint injury that bothers you? | | | Have you ever had a menstrual period? | |
| | Do any of your joints become painful, swollen, feel warm or look red? | | | How old were you when you had your first menstrual period? | |
| | Do you have any history of juvenile arthritis or connective tissue disease? | | | How many periods have you had in the last 12 months? | |
| | Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)? | | | CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR | |

## PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ☐ Male ☐ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected ☐ Y ☐ N

| MEDICAL | NORMAL | ABNORMAL | MUSCULOSKELETAL | NORMAL | ABNORMAL |
|---|---|---|---|---|---|
| Appearance, Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | | Neck | | |
| Eyes/Ears/Nose/Throat Pupils Equal Hearing | | | Back | | |
| Lymph nodes | | | Shoulder/Arm | | |
| Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) | | | Elbow/Forearm | | |
| Pulses: Simultaneous femoral and radial pulses | | | Wrist/Hand/Fingers | | |
| Lungs | | | Hip/Thigh | | |
| Abdomen | | | Knee | | |
| Genitourinary (males only) | | | Leg/Ankle | | |
| Skin: HSV: Lesions suggestive of MRSA, tinea corporis | | | Foot/Toes | | |
| Neurologic | | | Functional Duck Walk | | |

RECOMMENDATIONS: _____

**I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.**

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

**EXAMINER**

Name of Examiner (print/type): _____ Date: _____

Signature of Examiner: _____ (Check One): ☐ MD ☐ DO ☐ PA ☐ NP

DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE

## EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (_____)_____

IN EMERGENCY (1): _____ Home #: (_____)_____ Cell #: (_____)_____

IN EMERGENCY (2): _____ Home #: (_____)_____ Cell #: (_____)_____

Drug Reactions: _____ Current Medications: _____

Allergies: _____

# PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

**A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR**

Student Name: _____
LAST FIRST MIDDLE INITIAL

Student Address: _____
STREET CITY ZIP

Gender: ☐ M ☐ F Age: ____ Date of Birth: _____ Place of Birth (City/State): _____

School: _____ Circle Grade ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Father/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Mother/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old: _____

## STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements**.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume**; and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**: _____ Date: _____

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

## INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ☐ YES ☐ NO

If YES, Family Insurance Co: _____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE

## MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, _____, an 18-year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

*This Sports Health Questionnaire may only be used for students who received a valid sports physical during the 2019-20 school year (one completed on or after April 15, 2019). A school may require a student to have a valid physical exam.*

# 2020-21 MHSAA SPORTS HEALTH QUESTIONNAIRE

Date ____/____/____

Name _____ Age_____ Birth Date_____/_____/_____

Grade _____School_____Sport(s)_____

Address _____

Phone _____ Date of Last Sports Qualifying Physical Exam _____/_____/_____

**Check Yes or No for each question.**

**Since your last complete Sports Qualifying Physical Exam with your physician, HAVE YOU HAD ANY OF THE FOLLOWING?**

| | | YES | NO |
|---|---|---|---|
| 1. | Has a doctor ever restricted or denied your participation in sports for any reason without clearing you to return to sports? | ☐ | ☐ |
| 2. | Do you have a heart condition or has a doctor ever told you that you had an abnormal heart test (e.g., ECG, echocardiogram)? | ☐ | ☐ |
| 3. | In the last year, have you ever passed out or nearly passed out during or after exercise? | ☐ | ☐ |
| 4. | In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| 5. | In the last year, did your heart race, flutter in your chest or skip beats (irregular beats) during exercise? | ☐ | ☐ |
| 6. | In the last year, did you get light-headed or feel more short of breath than expected during exercise? | ☐ | ☐ |
| 7. | In the last year, have you had an unexplained seizure? | ☐ | ☐ |
| 8. | In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason? | ☐ | ☐ |
| 9. | In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including an unexplained drowning or an unexplained car accident)? | ☐ | ☐ |
| 10. | In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning? | ☐ | ☐ |
| 11. | In the last year, has anyone in your immediate family been diagnosed with a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | ☐ | ☐ |
| 12. | In the last year, has anyone in your immediate family before age 35 had a heart problem, pacemaker, or implanted defibrillator? | ☐ | ☐ |
| 13. | In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems? | ☐ | ☐ |
| 14. | In the last year, has a doctor restricted or denied your participation in sport due to a serious injury or medical condition without clearing you to return to sports? | ☐ | ☐ |

**Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important for the coaches and/or athletic director to know (attach additional notes if space below does not allow for complete comments). Schools may require a student to have a valid physical exam at their discretion.**

**I do not know of any existing physical or additional health reasons that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.**

_____ **Parent or Guardian or 18-Year-Old Signature**

_____ **Student Signature**

_____ **Date**

**FOR ATHLETIC DIRECTOR USE: A YES answer to any of the above questions requires a physical exam from a MD, DO, NP, PA prior to participation.**

**____ INFORMATION IS COMPLETE** **____ STUDENT REQUIRES FOLLOW-UP**

**Reference: Preparticipation Physical Evaluation (Fifth Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; AAP, 2019**

- - - - - - - - - - - - - - - - - - - - - - - - - - (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) - - - - - - - - - - - - - - - - - - - - - - - - - -

## EMERGENCY INFORMATION COMPLETED BY PARENT OR GUARDIAN OF 18-YEAR-OLD

Student:_____Grade: _____ Doctor: _____ Phone: (_____)_____

**IN EMERGENCY (1):**_____Home #: (_____)_____Cell #: (_____)_____

**IN EMERGENCY (2):**_____Home #: (_____)_____Cell #: (_____)_____

Drug Reactions:_____Current Medications: _____

Allergies:_____

# MHSAA SPORTS HEALTH QUESTIONNAIRE - CONSENT - INSURANCE

There are **FOUR (4)** signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

Student Name: _____
last first middle initial

Student Address: _____
street city zip

Gender: ___ M ___ F Age:___ Date of Birth:_____ Place of Birth (City/State):_____

School:_____ Grade:_____

Father/Guardian Name: _____

Phone (home):_____ (work):_____ (cell):_____

Mother/Guardian Name: _____

Phone (home):_____ (work):_____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old:_____

## STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.**

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**:_____ Date: _____

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____

## INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ___ YES ___ NO

If YES, Family Insurance Co:_____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical health questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____

## MEDICAL TREATMENT CONSENT COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I,_____, an 18-year-old, or the parent or guardian of_____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**:_____ Date: _____