

Mansfield Middle School Athletics Program: SPORTS PERMISSION FORM

STUDENT NAME: _____ AGE: _____ GRADE: _____

PARENT/GUARDIAN NAME: _____ DOB: ____ / ____ / ____

I give permission for _____ to participate in organized middle school athletics, realizing that such activity involves the potential for injury, which is inherent in all sports. I acknowledge that even with the best coaching, use of appropriate equipment and strict observance of rules, injuries are a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge that I have read and understand this warning, and agree not to hold the school district or its personnel responsible for any injury that may occur during practices, scrimmages, games, or transportation to athletic events.

Sports being played: 1. _____ 2. _____ 3. _____

Parent/Guardian Signature

Date

STUDENT EMERGENCY INFORMATION (* The best number to reach you during after school sports)

STUDENT ADDRESS: _____
Street Town

PARENT/GUARDIAN INFORMATION

Father's Name: _____ Home Phone: _____
Cell Phone: _____

Email Address: _____
Employer: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____
Cell Phone: _____

Email Address: _____
Employer: _____ Work Phone: _____

EMERGENCY CONTACTS

List two (2) neighbors or relatives who will assume temporary care of your child if you cannot be reached. (They must be at least 18 years old.)

1. Name: _____ Phone: (____) _____

2. Name: _____ Phone: (____) _____

AUTHORIZATION FOR FIRST AID AND MEDICAL TREATMENT

In case of accident, illness or injury, I grant permission for school personnel to administer first aid and/or secure medical treatment for my child. In the event of an emergency, your child will be taken to the nearest medical facility.

Parent/Guardian Signature: _____ Date: _____

Important Note to Parents/Guardians:

The MMS Health Room closes daily at 3:15. There is **no nursing coverage** for after school clubs, sports or activities. If your child has a known medical need (such as; asthma, severe allergy, seizures, diabetes...) and may need medication or medical supervision during after school sports, a parent/guardian must contact the school nurse in order to make the necessary plans or arrangements. The appropriate care and guidelines will be delegated to the coaches. MMS does not provide nursing coverage beyond the school day. These arrangements will need to be updated for each sport your child participates in each quarter. Call the health office with questions 429-9341.

MANSFIELD MIDDLE SCHOOL SPORTS PARTICIPATION HEALTH RECORD

This evaluation is to determine readiness for sports participation only

STUDENT NAME _____ **Age** _____ **Sex** _____ **Grade** _____ **Phone** _____

Address _____

SPORTS BEING PLAYED 1. _____ 2. _____ 3. _____

MEDICAL HISTORY

(To be completed by student and parent or guardian)

Do you have any allergies? (food, drugs, insect stings, etc.)

YES ___ NO ___ List: _____

Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally)

YES ___ NO ___ List: _____

Are you presently being treated for any condition by a physician or other health care professional?

YES ___ NO ___ Explain: _____

Have you ever been advised by a doctor not to participate in any sport?

YES ___ NO ___ Explain: _____

Do you have any chronic conditions, disorders or diseases?

YES ___ NO ___ if yes, check those applicable:

Asthma _____	Bleeding Disorders _____	Diabetes _____
Epilepsy (seizures) _____	Hepatitis (liver disease) _____	Sickle Cell Anemia _____
Hypertension (high blood pressure) _____	Mononucleosis _____ year _____	Kawasaki's Disease _____
Handicap (describe) _____	Other _____	

Please check where applicable if you have or have had any of the following:

YES	YEAR		YES	YEAR
___	___	Head injury, concussion, or been unconscious	___	___
		If yes, how many times _____	___	___
___	___	Headaches more than once a week	___	___
___	___	Lack of feeling or numbness in any part of the body	___	___
___	___	Heat exhaustion or heat stroke	___	___
___	___	Difficulty running 1/2 mile without stopping	___	___
___	___	Chest pain, dizziness or passing out during exercise	___	___
___	___	Coughing, wheezing or gasping for breath with exercise or cold weather	___	___
___	___	Smoke cigarettes or chew tobacco	___	___
___	___	Heart problem, murmur or arrhythmia	___	___
___	___	Family member with a heart attack under age 50	___	___
___	___	Loss or gain of more than 10 lbs. in last year	___	___
___	___	Special diet for medical reasons	___	___
		<i>For female participants:</i>	___	___
___	___	Absent or irregular monthly periods	___	___
___	___	Disabling cramps with your menstrual periods	___	___
		Eye injury or retinal detachment	___	___
		Blurred vision or vision in one eye only	___	___
		Wear glasses or contact lenses	___	___
		Hearing loss or impairment in one or both ears	___	___
		Tubes in ears or a perforated eardrum	___	___
		False teeth, caps or braces	___	___
		Nose bleeds for no reason	___	___
		Bruising easily or taking a long time to stop bleeding when cut	___	___
		Diarrhea more than once a week	___	___
		Black or bloody bowel movements (stools)	___	___
		Kidney disease or dark, brown or bloody urine	___	___
		Less than 2 kidneys or, in males, 2 testicles	___	___
		Lump(s) in armpit or groin	___	___
		Rash or skin problem	___	___
		Neck or spine or low back injury or pain	___	___

LIST ANY HOSPITALIZATIONS:

<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any injury (nerve, bone, muscle or joint) that you have had which did not allow you to participate in regular activity for a week or more.

<u>INJURED AREA</u> (Knee, hamstring, neck, etc)	<u>SIDE (R, L)</u>	<u>YEAR</u>	<u>TYPE</u> (Fracture, sprain, pinched nerve, swelling)	<u>RESOLVED Y/N</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

STUDENT AND PARENT OR GUARDIAN: We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

Student Signature _____ Date _____ Parent or Guardian Signature _____ Date _____

PHYSICAL EXAMINATION

Required within 24 months of Sports Participation
(To be completed by MD, APRN, or PA)

Student's Name _____ Birth Date _____ / _____ / _____ has had a history and physical exam on _____ / _____ / _____

	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular	Arrhythmia Murmur	
Abdomen		
Spine		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage)	1 2 3 4 5	

HEIGHT _____	WEIGHT _____
BLOOD PRESSURE _____	
HCT/HGB _____	
PULSE _____	
URINALYSIS _____	protein _____ blood _____ glucose _____
VISUAL ACUITY:	right _____ left _____
Corrected to	right _____ left _____
HEARING _____	
LAST TETANUS BOOSTER _____	
LAST MEASLES (MMR) BOOSTER _____	
OTHER IMMUNIZATIONS _____	
BODY FAT (optional) _____	
CHOLESTEROL (optional) _____	

SUMMARY: _____

ORTHOPEDIC EXAM MUSCULO-SKELETAL EVALUATION to include range of motion, strength, flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

RECOMMENDATIONS

Weight Loss / Gain _____	Medications _____
Strengthening _____	Special Equipment _____
Stretching _____	Bracing / Taping _____
Conditioning (Endurance) _____	

I certify that on this date, 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:

Provider Signature _____ Date _____ Telephone _____ Printed Name or Stamp _____