School Sponsored Athletic Physicals will be held ONE DAY ONLY for the 2019-2020 School Year

JUNE 3, 2019 - During School Hours

Your grades for this year's end and your overall semester attendance account for eligibility at the beginning of next year. Make sure your grades are passing and make sure you have not missed more than 20 days this semester of this school year to remain eligible when fall sports start.

Please complete physical packet in BLACK or BLUE ink only. *Please note that where indicated grade for current school year is for NEXT school year.

Physical from the SCHOOL doctor on June 3rd:

Fill out the following, sign, and turn in by **MAY 24, 2019** to the Jr. High Office:

1. Contact Information for Boosters Form;
2. Declaration of Primary Sport if more than 1 sport is being played at the same time;
3. PIAA Physical Sections 1-5, 6 is for the Doctor;
4. Proof of Insurance-Medical Release/Consent Form;
5. Helmet Release Form (Football only);
6. Bee Sting Form;
7. Permission for Medical Treatment Form;
8. Activity Fee – Checks made payable to Keystone High School in the amount of $100; Two sports at the same time $150 - **This check will NOT be deposited until after August 17th.**
9. Sign up for appointment with Mrs. Porter – paperwork and money must both be turned in to receive an appointment time;

Physical from your own doctor AFTER JUNE 1st, 2019:

Physicals must be dated AFTER JUNE 1st, 2019 – MUST BE TURNED IN NO LATER THAN AUGUST 2nd, 2019 *OR PRIOR TO ANY TEAM CAMP*

1. Contact Information for Boosters Form;
2. Declaration of Primary Sport if more than 1 sport is being played at the same time;
3. PIAA Physical Sections 1-5, 6 is for the Doctor* **- make sure Dr. signs & dates your physical!;**
4. Proof of Insurance-Medical Release/Consent Form;
5. Helmet Release Form (Football only);
6. Bee Sting Form;
7. Permission for Medical Treatment Form;
8. Activity Fee – Turn in with COMPLETED PHYSICAL PACKET only BY AUGUST 2nd to the HIGH SCHOOL OFFICE! Checks made payable to Keystone High School in the amount of $100; Two sports at the same time $150. **This check will NOT be deposited until after August 17th.**

NOTE: Any participation in Try-Outs or Team Camp(s) will require that you first have a new physical for the upcoming school year. You will not be permitted to participate if you do not have a new physical on file with the school.

CONTACT INFORMATION FOR BOOSTERS

This is so you may be notified of upcoming meetings, fundraisers, etc.

Check which sport(s) you are interested in participating in for next school year

FALL SPORTS: ______ GOLF (7th-12th) ______ FOOTBALL

______ CROSS COUNTRY ______ SOCCER (9-12 only)

______ VOLLEYBALL (9-12 only) ______ CHEER (Football)

WINTER SPORTS: ______ BASKETBALL (all grades) ______ WRESTLING

______ CHEER (Basketball) ______ CHEER (Competition)

SPRING SPORTS: ______ SOFTBALL (9-12 only) ______ BASEBALL (9-12 only)

______ TRACK & FIELD (9-12 only) ______ VOLLEYBALL (7-8 only)

PLEASE PRINT LEGIBLY

Athlete's Name ______________________________

2019-2020 Grade __________ Career Center Student? Yes No

Parent/Guardian Name: ______________________________

Best Phone Number to Call: ______________________________

Email Address of Parent: ______________________________

4/15/19

---

office use only:

1 2 3 4

____

____

Declaration of Primary Sport – Keystone High School

PLEASE FILL THIS FORM OUT IF YOU ARE PARTICIPATING IN
TWO OR MORE SPORTS THAT OCCUR AT THE SAME TIME

I ________________________________ declare the following sport as my primary

print name

sport ______________________________ and ______________________________ as

my secondary sport.

I understand that should a schedule conflict arise that my primary sport takes precedence. A written and signed excuse by the primary sport Head Coach is required for an athlete to miss a game, match, or meet (including make up games/meets). This note is to be kept on file in the Athletic Director's Office. If no excuse is obtained, the absence will be considered to be unexcused and subject to disciplinary actions according to the Athletic Handbook.

Athlete's Signature ____

Parent/Guardian's Signature ____

Date _________________

Primary Sport HEAD Coach

Signature____

Secondary Sport HEAD Coach

Signature____

Return COMPLETED form to Mr. Irwin by the first week of practice

4/26/19

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name ______________________________ Male/Female (circle one)

Date of Student's Birth: ____/____/______ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address ______________________________

Current Home Phone # (   )____________ Parent/Guardian Current Cellular Phone # (   )____________

Fall Sport(s): ____________ Winter Sport(s): ____________ Spring Sport(s): ____________

EMERGENCY INFORMATION

Parent's/Guardian's Name______________________________ Relationship ____________

Address ______________________________ Emergency Contact Telephone # (   )____________

Secondary Emergency Contact Person's Name ______________________ Relationship ____________

Address ______________________________ Emergency Contact Telephone # (   )____________

Medical Insurance Carrier______________________________ Policy Number____________

Address ______________________________Telephone # (   ) ____________

Family Physician's Name______________________________, MD or DO (circle one)

Address ______________________________Telephone # (   ) ____________

Student's Allergies______________________________

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware________

____

____

____

Student's Prescription Medications and conditions of which they are being prescribed ____________

____

Section 2: Certification of Parent/Guardian

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for ______________________________ born on ____________ who turned ______ on his/her last birthday, a student of ______________________________ School and a resident of the ______________________________ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature ______________________________ Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:

  The right equipment for the sport, position, or activity;
  Worn correctly and the correct size and fit; and
  Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature ______________________________ Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

Section 4: Understanding of Sudden Cardiac Arrest Symptoms and Warning Signs

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

______________________ ______________________ Date____/____/_____

Signature of Student-Athlete Print Student-Athlete's Name

______________________ ______________________ Date____/____/_____

Signature of Parent/Guardian Print Parent/Guardian's Name

Student's Name ______________________ Age________ Grade________

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

#	Question	Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	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? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes

#	Question	Yes	No
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever had a herpes skin infection?	☐	☐
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY	☐	☐
47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period?	______	
49.	How many periods have you had in the last 12 months?	______	
50.	Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature ______________________ Date___/___/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature ______________________ Date___/___/_____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name ______________________________ Age________ Grade________

Enrolled in ______________________________ School Sport(s) ______________________________

Height_______ Weight______ % Body Fat (optional) ______ Brachial Artery BP_____/_____ (_____/_____, _____/_____) RP_______

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:______________________________

☐ **NOT CLEARED** for the following types of sports (please check those that apply):
☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to ______________________________

Recommendation(s)/Referral(s) ______________________________

AME's Name (print/type) ______________________________ License #________________
Address______________________________ Phone (   )________________

AME's Signature__________________MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ___/___/___

KEYSTONE SCHOOL DISTRICT
HELMET RELEASE FORM

As an athlete, you are entitled to know that your helmet is a piece of equipment, which must be used in the proper manner. You must understand that the helmet is a protective device and not a weapon.

Do not strike an opponent with any part of this helmet or facemask. This is a violation of football rules and may cause you to suffer or cause to suffer severe brain or neck injury, including paralysis or death. Severe brain or neck injury may also occur accidentally while playing football. No helmet can prevent all such injuries. You are using this helmet at your own risk.

ATHLETE'S RESPONSIBILITY

1. Along with regular daily use of this helmet, you are responsible for daily maintenance checks. These daily maintenance checks will help you to ensure the safety of your helmet and provide you with the best protection for you.

2. Upon daily inspection of your helmet, if you notice any parts loose or missing, you are responsible for reporting it to the athletic trainer immediately.

3. You must wear a mouthpiece and chinstrap at all times while using this helmet.

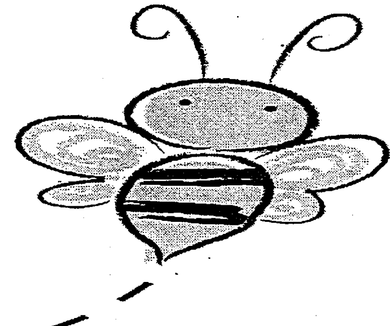
I have read and understand all instructions for the use of a football helmet for the 2019-2020 school year.

PRINT ATHLETE NAME ______________________________

ATHLETE SIGNATURE ______________________________

PARENT/GUARDIAN SIGNATURE ______________________________

4/26/19



PLEASE MARK ONE OF THE FOLLOWING:

_______ My child is NOT allergic to bees

_______ My child has never been stung so I am unsure if he/she is allergic to bees

_______ My child had an allergic reaction to bee stings and has an Epi-Pen with their name on it for the Athletic Trainer or the Coach to use in case of emergency

_______ My child has an allergic reaction to bee stings and needs an Epi-Pen but does not carry one

_______ My child has a minor reaction to bee stings and can be treated with Benadryl

Student Athlete Name: ______________________________

Sport(s): ______________________________

Parent/Guardian Signature: ______________________________

4/10/18

PROOF OF INSURANCE
MEDICAL RELEASE/CONSENT FORM

Name of insurance company:____

Address:____

Group #:________________ Policy #:________________ Phone:________________

Primary physician:__________________ Preferred hospital:______________________

ACKNOWLEDGEMENT OF RISK/CONSENT TO PARTICIPATE
CONSENT TO PERFORM PHYSICAL EXAMINATION

______________________ has parental consent to participate in ______________________.

Athlete's name sport

And receive a physical examination by the team physician or equal representative as deemed qualified by Keystone School District. I/We hereby acknowledge an awareness that participation in athletics involves a risk of injury, which may include severe injuries possibly involving paralysis, permanent mental disability or death, and that these injuries may occur in some instances as the result of unavoidable accidents. By signing this form, the parent acknowledges the risks involved and understands that the school will not be held responsible for any injury or damage. The parent/guardian assumes full responsibility for any injury or damage to his/her child through his/her hospital/insurance plan and accepts that Keystone School District will not be financially responsible for such instances. If the parent/guardian does not sign this form relieving the Keystone School District, it's coaches, certified athletic trainer, student athletic trainers, administrators, and other school officials from all responsibility regarding any injury or damage sustained during participation in interscholastic activities, his/her child will not be permitted to participate in that activity.

____

signature of parent/guardian

ATHLETIC TRAINING CARE/EMERGENCY AUTHORIZATION

I give permission to the Certified Athletic Trainer to evaluate, treat, and rehabilitate and recondition any injury sustained by my son/daughter during the course of an athletic season as she/he deems appropriate. This may or may not involve application of modalities. I hereby acknowledge that the Certified Athletic Trainer my contact the student's physician in order to obtain information concerning the extent of the injuries sustained, the extent to which a student may participate, and what additional treatment the physician may recommend. I hereby consent to the Certified Athletic Trainer to contact physicians, nurses, and hospitals/clinics to access my son/daughter's medical records that relate to PIAA eligibility. Information obtained by the ATC will be considered confidential and will be kept in compliance with HIPPA law. I also give my permission to the ATC employed by Keystone School District to perform immediate and emergency treatment to injuries incurred during any interscholastic activity involving Keystone teams, and if necessary, to transport him/her to the nearest medical facility. I give consent to the hospital or physician(s) to perform or administer emergency care to my son/daughter as deemed appropriate.

____

signature of parent/guardian

KEYSTONE SCHOOL DISTRICT

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to the certified athletic trainer, physician or other hospital personnel designated by Keystone School District Coaching Staff and/or Administration to attend to my child/ward.

ATHLETE INFORMATION: **19-20 Grade** ____________

NAME ______________________ DOB ____________

Parent/Guardian Information:

Name(s) ______________________ Preferred Phone Number: ____________

Email ______________________

I expect every effort will be made to contact me in order to receive my specific authorization before any treatment is made.

Parent Signature ______________________

IF PARENT/GUARDIAN CANNOT BE REACHED CONTACT:

NAME: ______________ Relationship: ____________ Phone: ____________

ATHLETE HEALTH HISTORY

	YES	NO
Allergies		
Medications		
Heart Condition		
Back/Spinal Problems		
Kidney Injuries		
Glasses		
Contacts		
Dentures/Partials		
Seizure Disorders		

Blood Type, If Known ____________

List Allergies: ______________________

List Medicine: ______________________

Family Doctor ______________________

Phone # ______________________

Insurance Co. ______________________

Sports Involved In:

Fall: ____________

Winter: ____________

Spring: ____________

4/26/19