AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

_____/_____/_____

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

_____/_____/_____

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

_____/_____/_____

Signature of parent / legal guard-

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

_____/_____/_____

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam**

_____/_____/_____

Are your immunizations up to ☐ Yes ☐ No

Last tetanus shot _____/_____/____

Last measles shot _____/_____/____

Last TB skin test _____/_____/____

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
2.	Have you or a household contact been diagnosed with COVID-19?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you presently taking any medications or pills?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
6.	Have you ever been dizzy during or after exercise?	☐	☐
7.	Have you ever had chest pain during or after exercise?	☐	☐
8.	Do you tire more quickly than your friends during exercise?	☐	☐
9.	Have you ever had high blood pressure?	☐	☐
10.	Have you ever been told that you have a heart murmur?	☐	☐
11.	Have you ever had racing of your heart or skipped beats?	☐	☐
12.	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
13.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
14.	Have you ever had a head injury?	☐	☐
15.	Have you ever had a concussion? If yes, how many_____	☐	☐
16.	Have you ever been knocked out or unconscious?	☐	☐
17.	Do you suffer from migraines?	☐	☐
18.	Have you ever had a seizure?	☐	☐
19.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
20.	Have you ever had heat or muscle cramps?	☐	☐
21.	Have you ever been dizzy or passed out in the heat?	☐	☐
22.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
23.	Do you use any medical assistant devices *(insulin pump, prosthetic, implanted device, etc.)*?	☐	☐
24.	Have you ever had problems with your eyes or vision?	☐	☐
25.	Do you wear glasses or contacts or protective eye wear?	☐	☐
26.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints?	☐	☐
	___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand		
27.	Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*?	☐	☐
28.	Have you had any medical problem or injury since your last evaluation?	☐	☐
29.	Are you Diabetic?	☐	☐
30.	Are you Asthmatic?	☐	☐
31.	Do you have any allergies *(medicine, bees or other stinging insects)*??	☐	☐

List all allergies: _____

32. When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

33. Explain all "yes" answers: _____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH REVIEW/EXAM

To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

Student Last Name	Student First Name	MI	Date of birth	Grade
			_____/_____/_____	

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of M.D., D.O. P.A., ANP, CHAP or DC (circle)	Signature	Date
		_____/_____/_____

Address	Phone