LAKE COUNTY SCHOOLS

SPORTS SCREENING PHYSICAL EXAMINATION

NOTICE TO PARENT/LEGAL GUARDIAN

Lake County Schools recommends that your child have a yearly comprehensive physical examination by your personal physician. The screening sport physical, given by volunteer doctors, are not intended to replace your child's regular health maintenance. It is the responsibility of the parent/guardian to make the choice for medical care regarding your child. It is your clear understanding that participation in athletic activities creates a risk normally associated with such activities and that the risk increases as the sport becomes more vigorous and/or involves bodily contact.

PARENTAL/LEGAL GUARDIAN & CHILD/WARD NOTICE OF RESPONSIBILITY & CONSENT FOR PARTICIPATION

As a parent/legal guardian of a student who will be participating in any Lake County School Board (LCSB) athletic activity, your authorization to permit your child/ward to participate requires you understand and agree to certain rules, responsibilities and regulations.

1. Athletics is a sports activity that will require your child/ward to maintain satisfactory grades and behavior in accordance with the LCSB Code of Conduct and school/team rules. Once a child is approved for sports activities you hereby give consent for participation.
2. You understand if a parent, guardian or student falsifies any signature or information on the sports screening physical examination form, the child/ward will be declared ineligible to participate in any Lake County interscholastic activity for one full calendar year from disclosure date.
3. You understand that your child/ward must have a physical evaluation each year and be certified as being physically fit to participate in interscholastic athletic programs. A physical evaluation shall be valid for a period not to exceed one calendar year from the date of practitioner's signature. The student cannot be allowed to participate in any activity related to interscholastic athletic programs until the fully executed physical evaluation form is on file in the school.
4. You further give permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold LCSB and its employees harmless in the administration of such assistance.
5. You understand that if the child/ward consults a medical physician concerning any injury received in a LCSB sponsored athletic practice or interscholastic sports contest, written medical approval must be obtained from a physician prior to the child/ward's further participation in activity. You understand that a written doctor's note on the doctor's stationary or prescription pad must be given to the athletic trainer or athletic director before that student will be allowed to resume activity.
   You also consent for your child to be transported in connection with participation in athletic activities. You fully understand that this consent is given knowing that your child/ward's participation in approved activities may, from time to time, require travel out of state as well as out of and within Lake County. You realize, and agree, that the travel may be by private or publicly owned vehicles, bus, passenger car, on foot or various other means, as deemed appropriate and approved by the school principal.
7. Athletics require that your child/ward and you commit to timely arrival and departure from the activity in accordance with the directive issued by the school principal or coach designated by the school principal to direct said activities. Your failure to timely pick up your child/ward may result in your child/ward's exclusion from the athletic activity.
8. You do authorize and give permission to the school principal, coaches, and school representatives to release your child at the conclusion of the athletic activity. You do authorize and give permission to your child to individually determine his/her method and means of returning to your home upon conclusion of any daily athletic activity including but not limited to his/her walking, riding with a friend, or any other means of transportation he/she chooses. If you have elected to give your child/ward permission herein, you hereby release the LCSB, its employees, agents, and assigns, from any and all liability or claim that may arise from or after your child/ward leaves the athletic activity.
   You do grant permission to the school principal, coaches, school representatives the right to photograph and/or videotape your child/ward and further to use name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, and promotional materials without reservation or limitation.
10. You do grant permission to LCSB to release any and all athletic injury information relating to the named athlete to the Sports Medicine Program Injury Registry.
11. In addition to the routine sports screening evaluation required by FHSAA Bylaws, you understand and acknowledge that you are hereby advised that your child/ward should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test provided by your personal physician.
    You further hereby authorize the use or disclosure of your child's/ward's individually identifiable health information should treatment for illness or injury become necessary. You understand that this authorization is voluntary and that you may revoke it at any time by submitting the revocation in writing to your child/ward's school principal.
    Hazing is defined as any method that causes, or is likely to cause, bodily danger or physical harm, or serious mental or emotional harm to any student. You understand activities that expose individuals to embarrassment, abuse, ridicule, or humiliation will not be tolerated and are subject to enforcement under the LCSB Code of Conduct, depending upon the seriousness of the violation.
14. You and child/ward have read and discussed the LCSB Code of Conduct and acknowledge that she/he may be disciplined or removed from a team if any of the provisions are violated.

I hereby acknowledge and certify that I have read the sports screening document.
I understand and agree to be bound by its terms.

Signature of Parent/Legal Guardian	Print Name of Parent/Legal Guardian	Date
Signature of Student	Print Legal Name of Student	Date

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Submitted by District Athletic Director

FAMILY / STUDENT HEALTH HISTORY

Student Name_____ DOB _____ Sex _____

Street Address _____

City_____ State_____ Zip Code _____

Home Phone _____ Other Phone(s) _____

Identify the answer for each of the following questions as well as circle any questions you are unable to answer. Explain "yes" answers on the next page.

YES	NO	Have you had a medical illness or injury since your last medical check or sports physical?
YES	NO	Do you have an ongoing chronic illness?
YES	NO	Have you ever been hospitalized overnight?
YES	NO	Are you currently taking any prescription or nonprescription medications or pills or using an inhaler?
YES	NO	Have you taken any supplements or vitamins to help you gain or lose weight to improve performance?
YES	NO	Do you have any allergies? (For example pollen, medicine, latex, food, or stinging insects)
YES	NO	Have you ever had a rash or hives develop during or after exercise?
YES	NO	Have you ever passed out during or after exercise?
YES	NO	Have you ever been dizzy during or after exercise?
YES	NO	Do you get tired more quickly than your friends do during exercise?
YES	NO	Have you had a severe viral infection? (For example: myocarditis or mononucleosis)
YES	NO	Do you have any current skin problems? (For example: itching, rashes, acne, warts, fungus, blisters or pressure sores)
YES	NO	Have you ever become ill from exercising in the heat?
YES	NO	Do you cough, wheeze, or have trouble breathing during or after activity?
YES	NO	Do you have asthma?
YES	NO	Do you have seasonal allergies that require medical treatment?
YES	NO	Have you had any problems with your eyes or vision?
YES	NO	Do you wear glasses, contacts, or protective eyewear?
YES	NO	Have you ever had a sprain, strain or swelling after injury?
YES	NO	Have you broken or fractured any bones or dislocated any joints?
YES	NO	Do you want to weigh more or less than you do now?
YES	NO	Has your weight fluctuated up or down over the past year?
YES	NO	If you are female, do you experience any problems with your period?
YES	NO	Do you use any special protective or corrective equipment or medical devices that aren't usually for your sport or position? (knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)
YES	NO	Have you ever been hospitalized? (Include date(s) in explanation)
YES	NO	Have you ever had surgery? (Include date(s) in explanation)

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YES NO Have you ever had a seizure?

YES NO Do you have frequent or severe headaches?

YES NO Have you ever had a head injury or concussion? (Include how many and how long ago)

YES NO Have you ever been rendered unconscious, or lost your memory?

YES NO Have you ever had a stinger, burner or pinched nerve?

YES NO Have you ever had numbness or tingling in your arms, hands, legs or feet?

YES NO Have you ever had chest pain during or after exercise?

YES NO Have you ever had racing of your heart or skipped heartbeats?

YES NO Have you had high blood pressure or high cholesterol?

YES NO Have you ever been told you had a heart murmur?

YES NO Have you ever been diagnosed with sickle cell anemia?

YES NO Have you ever been diagnosed with the sickle cell trait?

YES NO Has a physician ever denied or restricted your participation in sports for any heart problems?

YES NO Has any family member or relative died of heart problems or sudden death before age 50?

YES NO Have you had any injuries to, or experienced pain or swelling in muscles, tendons, bones, or joints?
If YES, check appropriate area and explain below:

head ___elbow ___neck ___ankle ___thigh ___back ___wrist ___toe ___hand
shin/calf ___shoulder ___finger ___upper arm ___foot ___forearm ___chest ___hip ___knee

Record the dates of your most recent immunizations (shots) for Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

EXPLAIN YES ANSWERS BELOW (If more space is needed; attach page.)

_____

_____

VERIFICATION OF MEDICAL INSURANCE

Know that I/we do hereby waive, relinquish, remise, and release the LCSB from any claim or cause of action which may arise as a result of my/our said minor child participating in the athletic program of the public school system of Lake County, insofar as I/we have elected to assume said risk, I/we have insured myself/ourselves against said risk. I/We further relieve and release said LCSB from any liability in its failure to provide insurance upon my/our said child/ward while he/she shall be engaged in the program of said public school system. I/We am providing information for medical insurance coverage for my child/ward. If I/we falsify any insurance information I/we understand that my child/ward will forfeit athletic eligibility from date of disclosure. The information below is required for participation. A copy of your valid insurance card must be attached; if you do not have family insurance you must purchase and sign below that you have football and/or school insurance for your child/ward.

Name of insurance company _____ Insurance policy number _____

Name of insurance contact _____ Insurance company phone number _____

_____ _____ _____

Signature of Parent/Legal Guardian Print Name of Parent/Legal Guardian Date

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PHYSICAL EXAMINATION (to be completed by licensed physician, licensed chiropractic physician, licensed osteopathic physician, licensed physician assistant or certified advanced nurse practitioner).

Student Name (please print) _____

List all sport(s) in which child/ward will participate. _____

Height _____ Weight _____ % Body Fat (optional) _____ Resting Pulse _____ Blood Pressure _____

Temperature _____ Hearing – Right P _____ F _____ Left P _____ F _____

Visual Acuity - Right: 20/_____ Left: 20/ _____ Corrected YES NO Pupils Equal_____ Unequal _____

MEDICAL FINDINGS	NORMAL	ABNORMAL FINDINGS
General Appearance	_____	_____
Eyes/Ears/Nose/Throat	_____	_____
Lymph Nodes	_____	_____
Heart	_____	_____
Pulses	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Genitalia (males only)	_____	_____
Skin	_____	_____
Musculoskeletal		
Neck	_____	_____
Back	_____	_____
Shoulder, Arm	_____	_____
Elbow, Forearm	_____	_____
Wrist, Hand	_____	_____
Hip, Thigh	_____	_____
Knee	_____	_____
Leg, Ankle	_____	_____
Foot	_____	_____

ASSESSMENT OF EXAMINING PHYSICIAN ASSESSMENT

_____ Cleared without limitation

_____ Disability _____ Diagnosis _____

_____

_____ Precautions _____

_____

_____ Disability _____ Diagnosis _____

_____

_____ Not cleared for _____ Reason _____

Recommendations _____

_____

Physician Signature _____ Date _____

Physician office stamp must be on this page.