**ACKNOWLEDGEMENT OF RISK / CONSENT – PARTICIPATION IN SPORTING EVENTS**

**2020-2021**

*Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***The following form is to be completed and signed, and submitted by every student and parent/guardian prior to student participation.***

***Statement of Consent and Acknowledgement***

By signing below, I hereby consent to the above-named student participating in interscholastic athletics. This consent includes travel to and from contests, training (running, walking,) on public roadways, practice sessions, and other related events.

By signing, I hereby acknowledge that I have reviewed and understand the information contained in this packet, and that I have been advised, cautioned, and warned by school officials about the risk of injuries associated with participation in athletic activities and sporting events, as that term is defined in under Utah law, and which includes but is not limited to, interscholastic or intramural camps, tryouts, practices, and competitions for school sanctioned sports, club sports, cheerleading, dance, drill team, or other activities where injuries are likely to occur. I am fully aware that participation in such athletic activities and sporting events exposes students to the risk of injury, ranging from, minor, to severe, including but not limited to: **sprains, fractures, partial or complete impairment of limbs, brain injury, paralysis, and even death.** I understand that coach instruction, protective equipment, and medical care provided do not eliminate these risks. I have addressed any questions or concerns with coaches or other school officials. Having been so cautioned and warned, it is still my desire to allow the above-named student to participate in athletic activities and sporting events, and I do so with full knowledge and understanding of the risks involved.

Signature of athlete \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wasatch Charter School Athletic Emergency Form**

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Two persons you recommend we call in the event you cannot be reached:  
1. Name/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical history and physical limitations or problems that should be known by the coach:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health/Accident Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As parent/legal guardian, I authorize and direct Wasatch Charter School to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any necessary medical and/or surgical procedures that are essential for the treatment of my child/ward and agree to be responsible for payment for such care. I release WCS, employees, volunteers and agents from any costs, damages, liability or loss resulting from the exercise of discretion in securing medical care for my child/ward.

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

■ **Preparticipation Physical Evaluation HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking |
|  |
|  |
| Do you have any allergies? Yes No If yes, please identify specific allergy below. Medicines Pollens Food Stinging Insects |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| GENERAL QUESTIONS  **Explain “Yes” answers below. Circle questions you don’t know the answers to.** | Yes | No | **MEDICAL QUESTIONS** | Yes | No |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? |  |  | 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? |  |  |
| 2. Do you have any ongoing medical conditions? If so, please identify  below: Asthma Anemia Diabetes Infections Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | 27. Have you ever used an inhaler or taken asthma medicine? |  |  |
| 3. Have you ever spent the night in the hospital? |  |  | 28. Is there anyone in your family who has asthma? |  |  |
| 4. Have you ever had surgery? |  |  | 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? |  |  |
| **HEART HEALTH QUESTIONS ABOUT YOU** | Yes | No | 30. Do you have groin pain or a painful bulge or hernia in the groin area? |  |  |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? |  |  | 31. Have you had infectious mononucleosis (mono) within the last month? |  |  |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? |  |  | 32. Do you have any rashes, pressure sores, or other skin problems? |  |  |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? |  |  | 33. Have you had a herpes or MRSA skin infection? |  |  |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  High blood pressure High cholesterol Kawasaki disease  A heart murmur A heart infection Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | 34. Have you ever had a head injury or concussion? |  |  |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) |  |  | 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? |  |  |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? |  |  | 36. Do you have a history of seizure disorder? |  |  |
| 11. Have you ever had an unexplained seizure? |  |  | 37. Do you have headaches with exercise? |  |  |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? |  |  | 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? |  |  |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | Yes | No | 39. Have you ever been unable to move your arms or legs after being hit or falling? |  |  |
| 13. 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)? |  |  | 40. Have you ever become ill while exercising in the heat? |  |  |
| 14. 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? |  |  | 41. Do you get frequent muscle cramps when exercising? |  |  |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? |  |  | 42. Do you or someone in your family have sickle cell trait or disease? |  |  |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? |  |  | 43. Have you had any problems with your eyes or vision? |  |  |
| BONE AND JOINT QUESTIONS | Yes | No | 44. Have you had any eye injuries? |  |  |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? |  |  | 45. Do you wear glasses or contact lenses? |  |  |
| 18. Have you ever had any broken or fractured bones or dislocated joints? |  |  | 46. Do you wear protective eyewear, such as goggles or a face shield? |  |  |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? |  |  | 47. Do you worry about your weight? |  |  |
| 20. Have you ever had a stress fracture? |  |  | 48. Are you trying to or has anyone recommended that you gain or lose weight? |  |  |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) |  |  | 49. Are you on a special diet or do you avoid certain types of foods? |  |  |
| 22. Do you regularly use a brace, orthotics, or other assistive device? |  |  | 50. Have you ever had an eating disorder? |  |  |
| 23. Do you have a bone, muscle, or joint injury that bothers you? |  |  | 51. Do you have any concerns that you would like to discuss with a doctor? |  |  |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? |  |  | **FEMALES ONLY** |  |  |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? |  |  | 52. Have you ever had a menstrual period? |  |  |
|  |  |  | 53. How old were you when you had your first menstrual period? |  |  |
|  |  |  | 54. How many periods have you had in the last 12 months? |  |  |

**Explain “yes” answers here ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.  
HE0503 *Page 3 of 4* 9-2681/0410

**■ Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues

• Do you feel stressed out or under a lot of pressure?

• Do you ever feel sad, hopeless, depressed, or anxious?

• Do you feel safe at your home or residence?

• Have you ever tried cigarettes, chewing tobacco, snuff, or dip?

• During the past 30 days, did you use chewing tobacco, snuff, or dip?

• Do you drink alcohol or use any other drugs?

• Have you ever taken anabolic steroids or used any other performance supplement?

• Have you ever taken any supplements to help you gain or lose weight or improve your performance?

• Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

|  |  |  |
| --- | --- | --- |
| **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 |  |  |
| Hearta  • 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 |  |  |
| Neurologicc |  |  |
| **MUSCULOSKELETAL** |  |  |
| Neck |  |  |
| Back |  |  |
| Shoulder/arm |  |  |
| Elbow/forearm |  |  |
| Wrist/hand/fingers |  |  |
| Hip/thigh |  |  |
| Knee |  |  |
| Leg/ankle |  |  |
| Foot/toes |  |  |
| Functional • Duck-walk, single leg hop |  |  |

aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

bConsider GU exam if in private setting. Having third party present is recommended.

cConsider 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. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If condi- tions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

HE0503 9-2681/0410