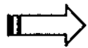
INSTRUCTIONS

- The examination and clearance must be given and signed only by an M.D. or D.O. licensed in Massachusetts.
- Print all 4 pages; follow these instructions.
- When filling out this form, please use black or blue ink only – no pencils, please.
- Please fill out page 2 completely. Make sure you and your parent/guardian date and signs the bottom.
- Read page 3; fill out information at the top; answer questions 1-15.
  - *explain any YES answers to these questions in the space provided.
  - * parent/guardian and athlete, both, must sign the bottom.
- After completing and signing both pages, bring the form to your Doctor. Have Dr. fill out page 4. Your Doctor's clearance *must* be on this form ~ *no other form will be accepted.*
- Please bring completed forms to the Athletic Office, Room 1405. It will be checked and status confirmed.
- Questions? Feel free to call the Athletic Office @ 508.790.9867.

Barnstable Public Schools

Permission for Medical Treatment, Athletic Medical Screening, and Athletic Participation



NOTE: Please fill out these forms **completely!** All lines *must* have information or the word "**NONE**". Thank you.

STUDENT'S FULL NAME: (Last)______________________ (First)____________________ (M.I.)__________

DATE OF BIRTH: ____/____/____ HOME PHONE: 508-________________ CELL PHONE:____________________

STUDENTS REGULAR DOCTOR:__________________________________ MD's PHONE #:____________________

STUDENT'S ALLERGIES:____

PARENT/GUARDIAN'S NAMES: (1)______________________________/Cell:______________________________

(2)______________________________/Cell:______________________________

GRANT OF PERMISSION TO TREAT: I, the undersigned parent or guardian of the Barnstable public school student named above, hereby authorize any of the teachers, administrators, coaches, athletic trainers, physicians, nurses, or EMT's affiliated with the Barnstable Public Schools to give permission to any physician, hospital, or other medical practitioner or facility for any treatment – medical, surgical, dental, or other – that may be necessary or desirable for the student's well-being in the event of illness or bodily injury. I authorize such treatment of said student by said affiliated athletic trainers, physicians, nurses, or EMT's. If major emergency surgical treatment is immediately required, I request that reasonable efforts be made to reach me for consultation, but such consultation is not a prerequisite for such treatment. I also give permission for the Athletic Trainer or Athletic Training staff to administer any Over the Counter medications as indicated.

GRANT OF PERMISSION TO EXAMINE AND TO PARTICIPATE: I agree that my child or ward may be examined by a physician employed or designated by Barnstable Public Schools, and by other medical personnel under the physician's supervision, to determine his or her medical clearance for athletic competition, and further agree that if he or she is so cleared, he or she may participate in interscholastic athletic programs sponsored by the Barnstable Public Schools. **I specifically acknowledge that said examination is a screening for the athletic activity in the Barnstable Public schools *ONLY*, and is not to be used, considered as, or valid as a general medical examination.**

VALIDITY AND COPIES OF AUTHORIZATION: *I agree that this authorization shall remain valid while the student is in the Barnstable Public Schools. I agree that a photocopy of this signed document shall have the same validity as the original.*

RELEASE OF RECORDS: I authorize release to the Barnstable Public Schools full copies of all medical records arising out of any treatment of said student; this authorization includes, but is not limited to, release of information subject to HIPPA and FERPA.

SEALED INSTRUMENT: I agree that I am executing this consent form as a sealed instrument.

VERIFICATION: I represent that all information on Pages 1 and 2 of this form is complete and accurate.

I am aware of the current Barnstable High School Head Injury Protocol. I agree to take the closed head training at NFHSLEARN.com and acknowledge the receipt of the parent/student closed head injury sheets with the report of Pre-Participation Injury/Concussion Reporting Form in the event my child is injured out of school.

Current medical conditions/medications:____

____

☐ None

______________ ______________________________ ______________________________

DATE SIGNED *SIGNATURE OF PARENT OR GUARDIAN* *SIGNATURE OF ATHLETE*

10/31/11

Student's Name: ____

Last First M.I. Gender Date of Birth

MEDICAL HISTORY *Each question must be completely answered, dated and signed by both student and parent/guardian*

1. Do you have any limitations or disabilities that may impact your participation in athletics? Yes ☐ No ☐
   - **If Yes,** give details ______________________________

2. Do you have, or have you ever had, an adverse reaction to any medicine, drug, stinging insect, food product, or other substance or environmental condition? Yes ☐ No ☐
   - **If Yes,** what was the reaction to? ______________________________
   - **Was the reaction life-threatening,** (for example, difficulty breathing, obstructed air-way, shock, cardiac trouble) i.e., a true allergy, **OR was it less severe** (for example, rash, nausea, itching) ______________________________

3. Has a doctor or other medical professional ever denied or restricted your participation in sports for more than one day? Yes ☐ No ☐
   - **If Yes,** when and why? ______________________________

4. During or after exercise, have you ever
   Passed out or nearly passed out? Yes ☐ No ☐ Had pressure in your chest? Yes ☐ No ☐ Had your heart skip beats? Yes ☐ No ☐
   - **If Yes** to any, please describe what happened ______________________________

5. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes ☐ No ☐
   - **If Yes,** give details ______________________________

6. Have you ever used an inhaler or taken asthma medication? Yes ☐ No ☐
   - **If Yes,** give details, including when ______________________________

7. Within the past two years, have you had a medical, or psychological condition lasting more than two weeks for which you were hospitalized, prescribed medication, placed on a special diet, or given any limitations of physical or other activity? Yes ☐ No ☐
   - **If Yes,** what, when and why? ______________________________

8. Are you *currently* taking any prescription or over-the-counter medications? Yes ☐ No ☐
   - **If Yes,** what and how often? ______________________________

9. Has a doctor ever told you that you have high blood pressure, high cholesterol, heart murmur, heart infection or any other medical problem? Yes ☐ No ☐
   If yes, please give details, including which and when ______________________________

10. Has any relative or member of your family died *suddenly* (other than by injury or accident) before age 50? Yes ☐ No ☐
    - **If Yes,** who, when, and why? ______________________________

11. Does any relative or member of your family have Marfan syndrome? Yes ☐ No ☐
    - **If Yes,** who ______________________________

12. Have you ever had surgery? Yes ☐ No ☐
    - **If Yes,** what problem, what procedure, and when performed? ______________________________

13. Have you ever had a bone or joint injury that required: X-rays, CT scan, MRI, surgery, injections, physical therapy, a cast, brace, or use of sling or crutches? Yes ☐ No ☐
    - **If Yes,** give details, including when ______________________________

14. Have you had a head injury that was diagnosed as a concussion, or that caused you to lose consciousness, to have memory loss, or to have headaches for more than two consecutive days? Yes ☐ No ☐
    - **If Yes,** give details, including when ______________________________

15. Have you ever had a seizure after the age of 5? Yes ☐ No ☐
    - **If Yes,** give details, including when ______________________________

If you are currently using an INHALER, currently carry an EPI-PEN; make sure to have it with you
[__] *I carry an INHALER* [__] *I carry an EPI-PEN*

DATE SIGNED: ____________________, 201__. We the undersigned student and parent/guardian each state under oath that our answers to the above fifteen questions are complete and accurate.

______________________________ ______________________________

Student **Parent or Guardian**

Student's Name: ____
Last First M.I. Gender Date of Birth

PHYSICIAN CLEARANCE

I certify that:

1) I am an MD or DO (or a Physician's Assistant or Registered Nurse Practitioner under MD or DO direction) duly licensed to practice by the Commonwealth of Massachusetts;

2) I have on this date reviewed the medical history of the named student furnished above; and

3) I have physically examined said student;

4) I represent and certify that based on said review and examination this student is cleared to participate in all secondary school interscholastic athletics with: (check one)

☐ No **physical, mental** or **dietary** restrictions

☐ The following restrictions: **(provide specifics below)**

____

Examiner's printed name and title: ______________________________

Examiner's full address, telephone number, and fax number: ____________

____

____

Date signed: __________**, 201**__ **Examiner's signature:** ________________