NORTHEAST OKLAHOMA ASSOCIATION OF HOMESCHOOLERS

NOAHJAGS.ORG

NOAH Athlete Information, Release and Medical Authorization

School Year: _____ New D Returning D Date of last athletic physical exam: _____

Athlete's Name: _____

Date of Birth: _____ Athletic Grade:_____

Home School ○ Tutorial ○ Name: _____ Parent's Names: _____

Address: _____ City: _____ State:_____ Zip: _____

Athlete's Home: (___) _____ Work: (___) _____ Cell: (___) _____

Parents' Home: (___) _____ Work: (___) _____ Cell: (___) _____

Athlete's Primary e-mail:_____

Parent's e-mail: _____

Questions of Good Standing:

○ Has your son/daughter been expelled or dismissed from a private, public or homeschool program in the past 12 months?

No ○ Yes ○ If yes, please attach a letter of explanation. _____

○ Are you current on all NOAH athletic fees?

Yes ○ No ○ If no, please attach a letter of explanation. _____

Emergecy Medical Authorization and Agreement to Christian Dispute Resolution

Emergency contacts other than parent or guardian:

1. Name: _____ Hm phone: _____ Other phone: _____

2. Name: _____ Hm phone: _____ Other phone: _____

Permission: I give permission for my child to participate in this activity. I understand that there are risks associated with competitive sports. In the event he/she is injured, I _____ waive and release all rights to any claim for damages against NOAH and its representatives. I further agree that any claim or dispute arising from or related to this agreement shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker™ Ministries (complete text of the Rules is available at www.Peacemaker.net). Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. The parties understand that these methods shall be the sole remedy for any controversy or claim arising out of this agreement and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision.

Medical Release: In the event my child suffers sudden illness, accident, or injury and neither parents nor guardians can be contacted, I give permission for any emergency treatment that is deemed necessary by a licensed physician.

Family physician: _____ Phone: _____

Pertinent medical information (diabetes, allergies, medications, etc.):

Parent(s) Signature: _____ Date: _____

Pre-Participation Physical Exam

Date of Exam: _____

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Age on Sept. 1st of this year: _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician: In case of emergency, contact: _____

Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

Yes No

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have an ongoing medical condition (like diabetes or asthma)?
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?
4. Do you have allergies to medicines, pollens, foods or stinging insects?
5. Do you think you are in good health?
6. Have you ever passed out or nearly passed out DURING exercise?
7. Have you ever passed out or nearly passed out AFTER exercise?
8. Have you ever had discomfort, pain or pressure in your chest during exercise?
9. Does your heart race or skip beats during exercise?
10. Has a doctor ever told you that you have (check all that apply):
    High Blood Pressure • High Cholesterol • A heart murmur • A heart infection
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
12. Has anyone in your family died for no apparent reason?
13. Does anyone in your family have a heart problem?
14. Has any family member or relative died of heart problems or of sudden death before age 50?
15. Does anyone in your family have Marfan syndrome?
16. Have you ever spent the night in a hospital?
17. Have you ever had surgery?
18. Have you ever had an injury, like sprain, muscles, ligament tear, or tendonitis, that caused you to miss practice or game? If yes, circle affected area below.
19. Have you had any broken or fractured bons or dislocated joints? If yes, circle below.
20. Have you had a bone or joint injury that requird x-rays, MRI, CT, surgery, injections, rehabilition, 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

21. Have you ever had a stress fracture?
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
23. Do you regularly use a brace or assistive device?
24. Has a doctor ever told you that you have asthma or allergies?
25. Do you cough, wheeze. or have difficulty breathing during or after exercise?
26. Is there anyone in your family who has asthma?
27. Have you ever used an inhaler or taken asthma medicine?
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
29. Have you had infectious mononucleosis (mono) within the last month?

Yes No

30. Do you have any rashes, pressure sores or other skin problems?
31. Have you had a herpes skin infection?
32. Have you ever had a head injury or concussion?
33. Have you been hit in the head and been confused or lost your memory?
34. Have you ever had a seizure?
35. Do you have headaches with exercise?
36. Have you ever had numbness, tingling, or weakness in your arrns or legs after being hit or falling?
37. Have you ever been unable to move your arms or legs after being hit or falling?
38. When exercising in the heat, do you have severe muscle cramps or become ill?
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
40. Have you had any problems with your eyes or vision?
41. Do you wear glasses or contact lenses?
42. Do you wear protective eyewear, such as goggles or a face shield?
43. Are you happy with your weight?
44. Are you trying to gain or lose weight?
45. Has anyone recommended you change your weight or eating habits?
46. Do you limit or carefully control what you eat?
47. Do you have any concerns that you would like to discuss with a doctor?

Females Only

48. Have you ever had a menstrual period?
49. How old were you when you had your first menstrual period?
50. How many periods have you had in the last 12 months?

Explain "Yes" Answers Here: (Attach additional sheets as needed.)

_____

_____

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: (Athlete/Parent or Guardian): _____ Date: _____

The student has family insurance: ○ Yes ○ No;

If yes, family insurance company name and policy number. _____

_____

NOTE: *CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.* ***NOTE:*** *HISTORY ANO ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION.*

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 4/05

Pre-Participation Physical Evaluation

Please Print

Date of Exam: _____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Body fat (optional): _____ %

Pulse: _____ BP (Initial BP): _____ Post Exercise: _____ 5 Min. post exercise: _____

Vision: R 20/___ L 20/ ___ Corrected Y ___N ___ Pupils: ____Equal ____Unequal

Medical	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		
MUSCULOSKELET AL		
Neck		
Back		
Shoulder/ Arm		
Elbow /Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Clearance

○ Cleared

○ Cleared after completing evaluation/rehabilitation for: _____

_____

○ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

Name & Title of Examiner (Print/Type): _____ Date _____

Address: _____ Phone: _____

Signature of Examiner: _____