



## NSAA Athletic and Activities Student and Parent Consent Form

School Year: \_\_\_\_\_  
Member High School: \_\_\_\_\_  
Name of Student: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Name of Parent(s), Guardian(s), or Person(s) in Charge: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_  
Address(es) of Student and Parent(s)/Guardian(s)/or Person(s) in Charge\*\*: \_\_\_\_\_

*\*\*Note: If Student and all Parents/Guardians do not live in the same household, please include all addresses and inform the Member School as this may impact eligibility.\*\**

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege and understand and agree that (a) by this Consent Form the NSAA has provided notice of the existence of potential dangers associated with athletic and activity participation; (b) participation in any activity may involve injury or illness of some type, including exposure to communicable diseases, and even catastrophic injury, paralyzation, and death; and (c) even the best supervision, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(2) Consent and agree to participation of the Student in NSAA activities subject to (a) all NSAA Bylaws and rules interpretations, including limitations on transfers and limitations on the use of the Student's name, image, and likeness when wearing school uniforms or engaging in commercial activity tied to the Student's participation in NSAA activities; and (b) the athletic and activities rules of the Member School;

(3) Consent and agree to the disclosure by the Member School to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student contained in the Member School's directory information or other similar policies, and any other records or documentation needed to determine the Student's eligibility and compliance necessary to participate in NSAA activities;

(4) Understand that (a) prior to athletic participation, a pre-participation release form signed by a health care professional must be signed and submitted to the Member School; and (b) for purposes of determining fitness to participate, injury, injury status, or emergency response, Parents may be asked to consent to the disclosure of confidential medical records or information. Records and information shared for this purpose will not be redisclosed to any entities outside of the health care provider(s), Member School, or NSAA;

(5) Consent and agree (a) to authorize licensed or trained individuals, including certified sports injury personnel, to evaluate and treat any injury or illness that occurs during the Student's participation in NSAA activities. This includes all reasonable and necessary care, treatment, and rehabilitation for these injuries that is made available by the Member school and/or the NSAA, including transportation of the Student to a medical facility if necessary; and (b) that Parents are obligated to pay for professional medical and/or related services; the NSAA and the Member School shall not be liable for payment of such services even if made available by the Member School or NSAA.

(6) Understand that the Student or Student's likeness being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests and that any such recording may be used for broadcast, sale, or display.

We, Parent(s) and Student, acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities, and agree that Student may participate in NSAA activities.

**Student Printed Name**

**Student Signature**

**Date of Signature**

\_\_\_\_\_  
**Parent(s) Printed Name(s)**

\_\_\_\_\_  
**Parent Signature(s)**

\_\_\_\_\_  
**Date of Signature(s)**

**AUTHORIZATION AND ACKNOWLEDGEMENT**

**WARNING: SERIOUS CATASTROPHIC AND PERHAPS FATAL INJURY MAY RESULT FROM ATHLETIC PARTICIPATION**

Many forms of athletic competition result in violent physical contact among players, the use of equipment that may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision will eliminate these risks. Students have suffered accidents resulting in death, paraplegia, quadriplegia, and other very serious permanent physical impairment while playing sports. By granting permission for your student to participate in athletic competition, you, the parent or guardian, acknowledge that such risk exists. Students will be instructed in proper techniques to be used in athletic competition and in the proper utilization of all equipment worn or used in practice and competition. Students must adhere to that instruction and utilization and must refrain from improper uses and techniques.

I understand the statement above and I understand that by allowing my student to participate in athletic events, I assume the risk that he/she may be injured, perhaps severely.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF CONDUCT CODE**

I understand that as a student representing the school district in activities, I am obligated to comply with the athletic handbook, including the code of conduct. **This means that I may not possess, use, or be at parties in the presence of alcohol, illicit drugs, or controlled substances at any time during the school term.** I understand that if I violate the code of conduct or other rules in this handbook, I may be suspended from participation in all co-curricular activities and/or school sponsored activities or events.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Student

\_\_\_\_\_  
Date

I understand that my student is obligated by this handbook, including the statements above.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent

\_\_\_\_\_  
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

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

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

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	<b>Yes</b>	<b>No</b>
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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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 \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

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

## PHYSICIAN REMINDERS

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

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ ( _____ / _____ )	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>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. 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 conditions 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 \_\_\_\_\_, MD or DO

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

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 conditions 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 \_\_\_\_\_, MD or DO

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
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Other information \_\_\_\_\_  
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