APPENDIX D


345 Healthwest Drive
Dothan, AL 36303
(334) 836-4523

1811 E. Main Street, Ste. 3
Dothan, AL 36301
(334) 828-7300

# MEDICAL SCREENING EXAMINATION FORM

DATE _____ School or Organization _____

Name _____
Last First Middle

Address_____
Street

_____
City State Zip

Parents e-mail address _____

Phone (_____) _____ S.S. # _____

Parents Work Phone (_____) _____

Date of Birth _____ Age _____ Sex _____

Name of Family Physician _____

CONSENT FOR SCREENING: The undersigned agrees to submit to a medical screening examination for athlete participation. I understand that this is a screening examination designed to identify common conditions or infirmities that would limit or prevent participation in athletic activities. This examination is not intended to be comprehensive and may not detect some types of latent or hidden medical conditions.

This is to certify that I have read and understand the above information and have given my permission and consent to the screening for athletic participation.

I hereby state that, to the best of my knowledge, the answers I have given on the medical examination are true and correct.

_____ _____
Student Athlete's Signature Date

_____ _____
Parent's Signature Date

## Disclosure of Protected Health Information
## And Consent for Treatment

I hereby authorize the athletic trainers, sports medicine staff and other health care personnel working with _____School to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at that school. I further understand that it is at my request to comply with the requirements of his/her school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and /or school administrators, chaplains and/or clergy members, officials of the Alabama High School Athletic Association and the Alabama Independent School Association.

I, _____ parent or guardian, of _____(student's name) understand that as a parent/legal guardian give authorization/consent for the disclosure of the student-athlete's protected health information while participating as an interscholastic athlete at _____School. I understand that my protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parental/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I the parent/legal guardian understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing to the school's athletic director, but if I do, it will not have any effect on the actions the school officials took in reliance on this authorization/consent prior to receiving the revocation. I further have been given a copy of the Privacy Notice, which explains my rights under the HIPAA Act. This authorization/consent expires one year from the date it is signed.

I hereby authorize the athletic trainer and sports medicine staff at _____School, to administer treatment and first aid pertaining to school sporting activities as necessary, to _____(student's name).

**REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS**

_____ _____

**Print Athlete's Name** **Signature of Parent/Legal Guardian**

_____

**Date**

Disclosure of Protected Health Information.doc

**ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION**

**Preparticipation Physical Evaluation Form**

**Revised 2018**

Revised 2018

**History**

Date_____

Name_____ Sex _____ Age_____ Date of birth _____

Address _____ Phone_____

School _____Grade _____ Sport _____

| Explain "Yes" answers below: | Yes | No |
|---|---|---|
| 1. Has a doctor ever restricted/denied your participation in sports? | ☐ | ☐ |
| 2. Have you ever been hospitalized or spent a night in a hospital? | ☐ | ☐ |
| Have ever had surgery? | ☐ | ☐ |
| 3. Do you have any ongoing medical conditions (like Diabetes or Asthma)? | ☐ | ☐ |
| 4. Are you presently taking any medications or pills (prescription or over-the-counter? | ☐ | ☐ |
| 5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)? | ☐ | ☐ |
| 6. Have you ever passed out during or after exercise? | ☐ | ☐ |
| Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| Have you ever had chest pain or discomfort in your chest during or after exercise? | ☐ | ☐ |
| Do you tire more quickly than your friends during exercise? | ☐ | ☐ |
| Have you ever had high blood pressure? | ☐ | ☐ |
| Have you ever been told that you have a heart murmur, high cholesterol, or heart infection? | ☐ | ☐ |
| Have you ever had racing of your heart or skipped heartbeats? | ☐ | ☐ |
| Has anyone in your family died of heart problems or a sudden death before age 50? | ☐ | ☐ |
| Does anyone in your family have a heart condition? | ☐ | ☐ |
| Has a doctor ever ordered a test on your heart (EKG, echocardiogram)? | ☐ | ☐ |
| 7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)? | ☐ | ☐ |
| 8. Have you ever had a head injury or concussion? | ☐ | ☐ |
| Have you ever been knocked out or unconscious? | ☐ | ☐ |
| Have you ever had a seizure? | ☐ | ☐ |
| Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs? | ☐ | ☐ |
| 9. Have you ever had heat or muscle cramps? | ☐ | ☐ |
| Have you ever been dizzy or passed out in the heat? | ☐ | ☐ |
| 10. Do you have trouble breathing or do you cough during or after activity? | ☐ | ☐ |
| Do you take any medications for asthma (for instance, inhalers)? | ☐ | ☐ |
| 11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? | ☐ | ☐ |
| 12. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| Do you wear glasses or contacts or protective eye wear? | ☐ | ☐ |
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)? | ☐ | ☐ |
| 14. Have you had a medical problem or injury since your last evaluation? | ☐ | ☐ |
| 15. Have you ever been told you have sickle cell trait? | ☐ | ☐ |
| Has anyone in your family had sickle cell disease or sickle cell trait? | ☐ | ☐ |
| 16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot | ☐ | ☐ |
| 17. When was your first menstrual period?_____ When was your last menstrual period?_____ What was the longest time between your periods last year?_____ | | |
| Explain "Yes" answers: _____ _____ _____ _____ _____ | | |

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

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

**FORM 5**



Rev. 2018 (*The revised 2018 form is the official form accepted by the AHSAA.)*

## Preparticipation Physical Evaluation

_____

Student's name

**Rule 1, Sec. 14** — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5 Rev. 2018) must be used. **A physical exam will satisfy the requirement for one calendar year through the end of the month from the date of the exam. For example, a physical given on May 5, 2018, will satisfy the requirement through May 31, 2019.**

### Physical Examination

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20 / ____ L 20 / ____ Corrected: Y N

Revised 2018

| | | | Normal | Abnormal Findings |
|---|---|---|---|---|
| COMPLETE | LIMITED | Cardiovascular | | |
| | | Pulses | | |
| | | Heart | | |
| | | Lungs | | |
| | | Skin | | |
| | | E.N.T. | | |
| | | Abdominal | | |
| | | Genitalia (males) | | |
| | | Musculoskeletal | | |
| | | Neck | | |
| | | Shoulder | | |
| | | Elbow | | |
| | | Wrist | | |
| | | Hand | | |
| | | Back | | |
| | | Knee | | |
| | | Ankle | | |
| | | Foot | | |
| | | Other | | |

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: ☐ Collision

☐ Contact

☐ Noncontact ____ Strenuous ____ Moderately strenuous ____ Nonstrenuous

Due to: _____

Recommendation: _____

_____

_____

Name of physician _____ Date _____

Address _____ Phone_____

Signature of physician _____, M.D. or D.O.

(Form must be signed and dated by the attending physician.)



Rev. 2018 (*The revised 2018 form is the official form accepted by the AHSAA.)*

REHABILITATION, INC.

**CONSENT FOR BASELINE CONCUSSION TESTING and RELEASE OF INFORMATION**

I give my permission for (Name of Child) _____

(Child's Date of Birth) _____

(Child's School Name) _____

To take part in baseline concussion ImPACT testing (Immediate Post-Concussion Assessment and Cognitive Testing) administered by Encore Rehabilitation at his/her school.

I understand that my child may need a post concussion test in the event that he/she sustains a concussion and may need to have more than one to be administered in order to achieve baselines status.

I understand that this is an online test and that data will be stored at ImPACT Applications Inc., in Pittsburgh, PA. I give my permission to Encore Rehabilitation to access data on my child through ImPACT Applications in order to provide proper medical care.

Encore Rehabilitation may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modification, if necessary.

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of Child's Doctor: _____

Name of Practice or Group: _____

Phone Number: _____

Student's Home Address: _____
*(Street)* *(City)* *(State)* *(Zip Code)*

Parent or guardian numbers (please indicate preferred contact number and time if necessary)

_____ (Home) _____ (Work)

_____ (Cell)