BROGDEN MIDDLE SCHOOL
MEDICAL ELIGIBILITY

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Your student-athlete must be ***"medically eligible"*** to participate in athletics at Brogden Middle School. Compliance is a simple process of completing and updating the six forms listed below on an annual basis. 1. **Medical History Form** - The Medical History Form should be completed by the parent/guardian of the student-athlete and be available for review by the physician when the physical exam is performed. 2. **Physical Examination Form** - The Physical Examination Form must be completed by a Licensed Physician, Nurse Practitioner, or Physician's Assistant. 3. **Assumption of Risk/Medical Treatment Release Form**- This form simply states that participation in athletics may result in injury and should injury occur you have given your permission for treatment to be provided. 4**. HIPAA** - The HIPAA Form allows us to share information, should an injury or condition occur, with people like doctors and coaches. 5. **Student-Athlete Critical Contact Information Form** - The Critical Contact Information Form contains important information necessary for emergency or urgent care to be provided for your student-athlete in the parent/guardians absence. 6. **Concussion: Student-Athlete Form Concussion: Parent Form** are both in compliance with the Gfeller-Waller Concussion Awareness Law.

_____ 1. North Carolina High School Athletic Association Sport Participation Examination Form which is also referred to as the **Medical History Form**

_____ 2. **Physical Examination Form** (This form must be completed, and the student- athlete cleared, by a Licensed Physician, Nurse Practitioner, or Physician's Assistant)

_____ 3. Durham Public Schools **Assumption of Risk/ Medical Treatment Release Form**

_____ 4. Authorization for Release of Protected Health Information which is also referred to as **HIPAA**

_____ 5. Student –Athlete **Critical Contact Information Form**

_____ 6. **Concussion: Student-Athlete Form/Parent Legal Custodian Form**

Safety of our student-athletes by avoiding preventable injury or condition while they participate in athletics is a goal of the utmost importance. A student-athlete being ***"medically eligible"***, by having completed and updated the five forms listed above, is critical in helping us achieve this goal while enabling us to provide a high standard of care in the event that an injury or condition were to occur.

Coach Broadway Phone: (919) 560- 3906 Ext
Athletic Director Email: Kenneth.Broadway@dpsnc.net

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: ______________________________ **Age:** __________

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
Parent's Directions: Please assure that all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.
Physician's Directions: We recommend carefully reviewing these questions and clarifying any positive answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Has the athlete ever been hospitalized or had surgery?	❑	❑	❑
2. Is the athlete presently taking any medications or pills?	❑	❑	❑
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
5. Has the athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
6. Has the athlete had extreme fatigue associated with exercise (different from other children)?	❑	❑	❑
7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
8. Has the athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
9. Has a doctor ever told the athlete that they have high blood pressure?	❑	❑	❑
10. Has a doctor ever told the athlete that they have a heart infection?	❑	❑	❑
11. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told they have a murmur?	❑	❑	❑
12. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
13. Has the athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
15. Has the athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
16. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
17. Has the athlete ever had any problems with their eyes or vision?	❑	❑	❑
18. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	❑	❑	❑
❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot			
19. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	❑	❑	❑
21. Has the athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
22. Does the athlete have the sickle cell trait?	❑	❑	❑
FAMILY HISTORY	❑	❑	❑
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
24. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
25. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Elaborate on any positive (yes) answers: ______________________________

____

____

____

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in sports.

Signature of parent/legal custodian: ______________________ Date: __________

Signature of Athlete: ______________________ Date: __________ Phone #: __________

Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant)

Athlete's Name____ **Age**______ **Date of Birth** ______________________

Height__________ **Weight**__________ **BP** ______ (___ % ile) / ______ (___ % ile) **Pulse**____

Vision R 20/________ **L 20/**________ **Corrected: Y N**

These are required elements for all examinations			
	NORMAL	**ABNORMAL**	**ABNORMAL FINDINGS**
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			
Optional Examination Elements – Should be done if history indicates			
HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance:**

- ❑ **A. Cleared**
- ❑ **B. Cleared after completing evaluation/rehabilitation for :**______________________________
- ❑ **C. Not cleared for:** ❑ **Collision** ❑ **Contact**

  ❑ **Non-contact** _____**Strenuous** _____**Moderately strenuous** _____**Non-strenuous**

  Due to:____

Additional Recommendations/Rehab Instructions:____________________________________

Name of Physician/Extender:________________________________

Signature of Physician/Extender________________________ **MD DO PA NP**

(Signature <u>and</u> circle of designated degree required)

Date of exam:________________

Address: ________________________________

Phone____________________________

Physician Office Stamp:

(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee December 2009, and the NCHSAA Board of Directors reviewed annually.

Durham Public Schools
Assumption of Risk/Medical Treatment Release

Student Athlete's Name ____
School ____
Sport(s) ____ Date ________________

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The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics. By signing below, I (Parent/Guardian Name) ___________________________________, do understand:

1. The rules and procedures of the sports listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and hereby give my permission for my son/daughter to participate in any and all interscholastic athletic events sponsored by Durham Public Schools.

Permission is hereby granted to Durham Public Schools and its authorized representatives to initiate treatment and rehabilitation of injuries and authorize any needed emergency major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participant by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest/safety of the above named individual may be rendered.

I hereby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including, but not limited to, its coaches, certified athletic trainers, first responders, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools. I do, hereby, agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

****

Are you presently taking any medications, supplements, or pills? Yes ______ No ______
If yes, please list: ____

Does student named above have any allergies? (medicines, beestings, hay fever, etc.)Yes _____ No _____
If yes, please list: ____

Parent/Guardian Contact: Name ____
Phone #: Primary _________________ Secondary___________________ Cell ________________
Address: _____________________________ City: _____________________ Zip: ___________

Emergency Contact: Name ____
Phone #: Primary _________________ Secondary___________________ Cell ________________

<u>SIGNATURE</u>: **(Parent/Guardian):** _______________________________ Date: ____/____ /20____

Revised 5/4/2011

Please Read the Following Form Carefully

Authorization For Release of Protected Health Information For Athletic Participating In Durham Public Schools Athletics Program

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as "Athlete"), I herby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation *is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools.* As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: __________

____
Parent/Guardian Signature

____
Printed Name Relationship to Athlete

____
Athlete's Name - Printed

**This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parents who has the authority to act on the Athlete's behalf. By signing this form, you as the parent/guardian or party acting in loco parents warrant that you have the legal authority to act on the Athlete's behalf.

**The signature may be only the Athlete if the Athlete is over 18 years of age or legally emancipated person.

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Student-Athlete Critical Contact Information

Today's Date: ______/______/______ School Year: ________________

Name: ____ Class of: ____________________
(Last) (First) (Middle)

Gender: M F Date of Birth: ____/____/____ Social Sec. # __________________ School ID#: _____________

Parent / Legal Custodian Information: **(Social Sec. # Optional)**

Father's Name ________________________________ Father's Work# (____) __________________

Employer ________________________________ Father's Cell / Pager # (____) __________________

Mother's Name ________________________________ Mother's Work# (____) __________________

Employer ________________________________ Mother's Cell / Pager # (____) __________________

Street Address ____ County: __________________

City ____________________ State ____________ Zip Code_____________ Home Phone: (____) ______________

Alternate Emergency Contact: ____ Phone: (____) ______________

Athlete Medical Information:

1. Are you **ALLERGIC** to any type of medication? **Y / N** List: ________________________________
2. List any other allergies: ____
3. Do you take medications regularly? **Y / N** List: ________________________________
4. Do you take medicine for emergency use? **Y / N** List: ________________________________
5. Do you have **ASTHMA?** **Y / N** If so, do you use an inhaler? **Y / N** What kind? ________________
6. During athletic participation, do you wear: glasses? **Y / N** contacts? **Y / N** dental appliance? **Y / N**
7. Do you have any other medical conditions? **Y / N** List: ________________________________
8. Have you ever had a head injury, been knocked out, or had a concussion? **Y / N** List: ________________
9. Have you ever had discomfort, pain, or pressure in your chest during or after exercise or complained of your heart "racing" or "skipping beats"? **Y / N** List: ________________________________

Family Physician: ______________________ **Phone#:** ________________________

Insurance Information

Provider Name: ____________________________ Policy or Group # ____________________

Policy Holder's Name: ______________________ Phone# ____________________

Medical Authorization – As the parents or legal custodian of this student athlete I grant permission for treatment deemed necessary for a condition arising during or affecting participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. Also, permission is granted to release medical information to the school and athletic trainer. This permission is valid during the entire duration of the student-athlete's enrollment at Northern Durham High School, unless revoked by me in writing.

Risk of Injury – We acknowledge and understand that there is a risk of injury in athletic participation. We understand that the student-athlete will be under the supervision and direction of a DPS athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor the DPS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

________________________________ ________________________ __________
Student-Athlete (Print): (Signature): Date:

________________________________ ________________________ __________
Parent / Legal Custodian (Print): (Signature): Date:

CONCUSSION

INFORMATION FOR *STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS*

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. **You should not return to play or practice on the same day as your suspected concussion.**

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Student-Athlete & Parent/Legal Custodian Concussion Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name:____

This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodian Name(s):____

☐ We have read the *Student-Athlete & Parent/Legal Custodian Concussion Information Sheet.*
If true, please check box.

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

_______________________________ _____________
Signature of Student-Athlete Date

_______________________________ _____________
Signature of Parent/Legal Custodian Date

|

Durham Public Schools
Student Athletic Address Documentation Form

This is to certify that ___________________________________ (parent/guardian) of ___________________________________ (athlete) in Durham Public Schools do certify that my primary residence is located in the attendance zone of ___________________________________ School. This is my primary domicile (living resident) and I realize that for athletic purposes I can only have one primary domicile (living residence).

I further understand that this residence must be inside of the Durham Public Schools Administrative Unit. I certify that my address _______________________________________ is within the said district and that the school in which my child attends is in the attendance zone for the school that he/she is currently attending.

If I am not attending the school that is my normal attendance zone assignment, I am attending this school because the Office of Student Assignment has issued an approved student transfer or an approved program assignment for me to attend my current school valid for the current school year.

I also realize that if I have given an incorrect or false address that my child will be declared ineligible to participate in the school sports program. My signature further signifies that I have completed this form and that I fully understand the consequences associated with giving information that is incorrect and false.

Parent/Guardian Signature __________________________ Date Signed ________

Student Signature ________________________________ Date Signed _________

Witness ____ Date Signed ________