Parental Consent for Participation

I hereby give my consent for the above student to engage in approved sports activities. I also give my consent for my student to be transported in connection with participation in athletic activities. It is my clear understanding that participation in athletic activities creates risks normally associated with such activities and that the risk increases as the sport becomes more vigorous and/or involves bodily contact. I further give my permission for appropriate school staff or their designees to render emergency treatment associated with an injury and agree to hold the school district and its employees harmless in the administration of such emergency assistance.

Parent/Guardian Signature _____ Date: _____

Physician's Statement (To be completed by examining physician.)

Absolute Contraindications:

1. Three concussions
2. Large cranial defect
3. History of retinal detachment
4. Absence of one eye
5. Amblyopia of one eye 20/200
6. Congenital glaucoma
7. Symptomatic lung infection
8. Severe mitral stenosis
9. Cyanotic heart disease
10. Aortic stenosis
11. Active myocarditis
12. Symptomatic pulmonary hypertension
13. Blood coagulation defects
14. Any enlarged abdominal organ
15. Undescended testicle over pubic tubercle
16. Chronic osteomyelitis
17. Symptomatic spinal epiphysitis
18. Painful spondylolisthesis or spondylolsis
19. Active kidney problems

Height _____ Weight _____ Resting Pulse _____ Blood Pressure _____

Visual Acuity: with glasses Both _____ R____L_____

without glasses Both _____ R____L_____

Urine: Protein/Sugar _____

Head _____ Lungs _____ Scoliosis _____

Eyes _____ Heart _____ Back _____

Ears _____ Abdominal _____ Upper Extremities _____

Mouth _____ Hernia _____ Lower Extremities _____

Teeth _____ Genitalia _____ Skin _____

Neck _____

N = normal

X = abnormal

O = not examined

I certify that _____ has been examined by me on _____. He/she is physically qualified to participate in contact sports (football, wrestling, basketball, soccer) and non-contact sports, with the following limitations:

_____

_____

_____

_____

Physician's Signature _____ Date _____

Use this section for additional notations

PLUMAS UNIFIED SCHOOL DISTRICT – MEDICAL/PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

Student Name: _____ Date of Birth: _____
Address: _____ Sex: _____
School: _____ Grade: _____ Sports: _____

Family History (Parents)

	Yes	No
High Blood Pressure	☐	☐
Strokes	☐	☐
Heart Trouble	☐	☐
Blackout Spells	☐	☐
Seizures or Fits	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Sudden Deaths	☐	☐
Blindness	☐	☐
Bleeding Disorders	☐	☐

Explain all yes answers:

_____
_____
_____
_____
_____

Medical History (Student)

Have you ever had the following illnesses?

	Yes	Date	No
TB	☐	____	☐
Mononucleosis	☐	____	☐
Rheumatic Fever	☐	____	☐
Measles	☐	____	☐
Chicken Pox	☐	____	☐
Mumps	☐	____	☐
Diabetes	☐	____	☐

Medical History (Student continued)

Allergies: None_____

_____
_____
_____
_____

Medications: None_____

_____
_____
_____
_____

Hospitalizations: None_____

_____
_____
_____
_____

Operations: None_____

_____
_____
_____
_____

Immunizations:	Date
DPT	_____
Mumps	_____
Measles	_____
Polio	_____
Rubella	_____

Health History (Student)

Have you recently had or do you now have:

	Yes	No
Frequent headaches	☐	☐
Concussion	☐	☐
Seizures or Fits	☐	☐
Blackouts	☐	☐
Heat Stroke	☐	☐
Double Vision	☐	☐
Eyeglasses or Contact Lens	☐	☐
Blindness of Either Eye	☐	☐
Dental Appliances (braces, false teeth)	☐	☐
Dizzy Spells	☐	☐
Poor Hearing	☐	☐
Frequent Earaches	☐	☐
Nosebleeds	☐	☐
Rapid Heart Beat at Rest	☐	☐
Irregular Heart Beat	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
Swollen Ankles (other than sprains)	☐	☐
Shortness of Breath	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Other Lung conditions	☐	☐
Chest Pain	☐	☐
Constant Coughing	☐	☐
Ulcers	☐	☐
Worms	☐	☐
Yellow Jaundice	☐	☐
Unexplained Fevers	☐	☐
Kidney Problems	☐	☐
Bladder Infections	☐	☐
Blood in Urine	☐	☐
Blood Transfusion	☐	☐
Anemia (low blood)	☐	☐
Thyroid Trouble	☐	☐
Free Bleeding	☐	☐
Easy Bruising	☐	☐
Hot or Cold Spells	☐	☐
Arthritis	☐	☐
Knee injury	☐	☐
Knee pain	☐	☐
Dislocations	☐	☐
Fractures	☐	☐
Neck Injury	☐	☐
Weak Ankles	☐	☐
Back Ache	☐	☐

Explain all yes answers:

_____
_____
_____

I certify that the information on the above form is true:

Parent/Guardian Signature: _____

Business Phone: _____ Home Phone: _____