Bertrand Community School

Kindergarten, 7th Grade, New Student & Athletic Physical

Pre-Participation Physical Evaluation

CLEARANCE FORM

(This page to be complete by physician/nurse practitioner/physician assistant)

Grade ____

PHYSICAL EXAMINATION DATE OF EXAM _____

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ PULSE _____ BP _____

VISION R 20/ _____ L 20/ _____ CORRECTED? Y____ N____ COLOR BLIND Y____ N____

PUPILS: EQUAL ____ UNEQUAL ____ DATE OF LAST DT/Tdap _____

Circle the correct one

Certification of Immunization

Please complete or attach copy

Immunization	Record Complete Dates (month, day, year) of Vaccine Doses Given				
Diphtheria, Tetanus, Pertussis (DTP. Dtap)	1	2	3	4	5
Diphtheria, Tetanus, (DT) or Td (given after 7 years of age)	1	2	3	4	5
Poliomyelitis (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b (Hib conjugate)	1	2	3	4	
Pneumococcal (PCV conjugate)	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella	1	2	Serological Confirmation of Measles Immunity:		
Mumps	1	2			
Hepatitis B Vaccine (HBV)	1	2	3		
Varicella Vaccine	1	2	Date of Varicella Disease:		
HPV	1	2	3		
Meningoccal	1				

Physical Evaluation

	NORMAL	ABNORMAL FINDING
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back (Scoliosos)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Prescriptions and OTC medications taken regularly _____

Allergies _____

Operations _____

Important health-related information or chronic illnesses (diabetes, asthma, etc.) _____

THIS SIDE MUST BE COMPLETED FOR THIS IS AN ATHLETIC PHYSICAL

"I CERTIFY THAT I HAVE ON THIS DATE EXAMINED THIS STUDENT AND THAT, ON THE BASIS OF THE EXAMINATION REQUESTED BY THE SCHOOL AUTHORITIES AND THE STUDENT'S MEDICAL HISTORY AS FURNISHED TO ME, I HAVE FOUND NO REASON WHICH WOULD MAKE IT MEDICALLY INADVISABLE FOR THIS STUDENT TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES, EXCEPT:

Date of Examination _____ Clinic Name _____ Telephone _____

SIGN HERE PHYSICIAN'S SIGNATURE _____

_____
(Physician's Printed Name)

BERTRAND COMMUNITY SCHOOL STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM

STUDENT APPROVAL

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association. I will adhere to the rules and regulations set forth by the Coaching Staff and the Nebraska School Activities Association. Furthermore, I understand that I will be held responsible for athletic equipment checked out to me. I recognize that it is a privilege to compete in athletics and will strive to earn respect for myself, my school, and the community.

Circle Activities Student Will Be Participating In During the School Year 20____- 20_____

Basketball Cross Country Football Golf Track Cheerleading Volleyball Wrestling Speech Music Play Production

SIGN HERE STUDENT'S SIGNATURE _____

PARENT'S OR GUARDIAN'S PERMISSION

"I/We hereby give my/our consent for the above named student (1) to represent his/her school in athletic activities, allowed by the examining physician and approved by the State Association; (2) to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I/We authorize the school to obtain, through a physician of its own choice, any emergency medical care that may be reasonably necessary for the student in the course of such athletic activities or such travel. I/We also agree not to hold the school or anyone acting in its behalf responsible for any injury occuring to the above named student in the course of such athletic activities or such travel.

I/We realize that such athletic activity involves the potential for injury which is inherent of all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of rules, injuries are still a possibility. On rare occasions these injuries can result in total disability, paralysis, or even death.

I/We understand that the school carries no insurance on my/our child to cover medical expenses incurred while participating, and I/we will assume all such expenses myself/ourselves. (NOTE: Examine your insurance policies carefully to make sure they cover interscholastic athletic participation.)

My/Our Son/Daughter is covered by _____ Insurance Company.

SIGN HERE PARENT'S/GUARDIAN'S SIGNATURE _____

_____
(Printed Name)

_____
Address Phone #

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RELEASE FOR ATHLETES

We, the undersigned, agree to allow the release of medical information gathered from injury or injuries received in sports or conditions effecting sports participation, for our daughter or son. This medical information may be released or shared with one or more of the following entities: Coach, Assistant Coach, Activities Director, Activities Secretary, Certified Athletic Trainer, School Nurse, Family Physician, Physician Specialist, Physician Assistant, PT & PT Assistant.

We understand that our daughter or son cannot be denied medical care as a result of our refusal to sign this form.

We understand that if this information is disclosed to a non-covered entity, this information is no longer covered under the HIPAA Act.

We understand we have the right to withdraw our consent of this agreement. This withdrawal shall be made in writing prior to the onset of the injury in question

SIGN HERE PARENT'S/GUARDIAN'S SIGNATURE _____ _____ 20 _____