



PRE-REGISTRATION (2018)

THE SCHOOL DISTRICT OF PHILADELPHIA

This Free Sports Physicals Event is Sponsored by the Office of Athletics & the Athlete Health Organization (AHO)

IF YOU ARE MAKING MULTIPLE COPIES - PRINT SINGLE SIDED ONLY

PUBLIC, CHARTER & CATHOLIC/PAROCHIAL SCHOOLS ARE WELCOME!!!

SUNDAY, JUNE 10, 2018

Wells Fargo Center

3601 S Broad St, Philadelphia, PA 19148

P.I.A.A. REQUIRED FORMS FOR STUDENT ATHLETES

MANDATORY ATHLETIC FORMS ~ COMPREHENSIVE MEDICAL EXAM ~ PARENTAL PERMISSION FORMS

(THESE FORMS ARE ONLY FOR SCHOOL YEAR 2017-2018)

SCHOOL NAME _____

Please enter the school that you currently attend

STUDENT NAME _____

ID# _____

PRINT SINGLE SIDED ONLY

ALL FORMS SHOULD IMMEDIATELY BE COMPLETED AND RETURNED BACK TO THE ATHLETIC DIRECTOR AT YOUR SCHOOL.
TRANSPORTATION MAY BE REGIONALLY ARRANGED FOR ALL PUBLIC SCHOOLS PENDING ON # OF RETURNED FORMS.
GROUP TIME SLOTS WILL BE ASSIGNED TO ALL SCHOOLS AND COMMUNICATED TO THE ATHLETIC DIRECTOR.

Please Note: This examination is **NOT** a substitute for a yearly physical exam performed by your Family Doctor or Internist.



PARENT/GUARDIAN INFORMATION & CHECKLIST

Dear Parent/Guardian:

The School District of Philadelphia in partnership with the Athlete Health Organization (AHO) is pleased to offer **FREE** comprehensive physicals and medical screenings to all student-athletes of Public, Charter, and Parochial/Catholic Schools.

The physical exams are required by the Pennsylvania Interscholastic Athletic Association (PIAA) for all student-athletes interested in participating in any school sports activities.

The School District of Philadelphia has been fortunate to make this an annual event. The next scheduled screening date is **Sunday, June 10, 2018** at the Wells Fargo Center located at 3601 S Broad St, Philadelphia, PA 19148.

A packet for each student (along with a parent/guardian signature) is required prior to implementing the screening. A parent/guardian does not have to be present with the student athlete if a parent/guardian signature is provided on the requested documents.

It is best that the entire packet is entirely completed and returned back to the Athletic Director (AD) at the school who will, in turn, submit all forms to our office. The AD will receive further instructions regarding a group time slot and transportation. If the student athlete is not arriving with a group, he/she may individually go through the screening during an earlier hour.

Please complete all forms included. All forms are REQUIRED

Page 1 - Write School Name, Student Name and ID

Page 2 - Parent/Guardian Check list- no signatures required

Pages 3 & 4 - School District Consent Form- Parent/Guardian signature required on page 4

Page 5 - AHO release form - Parent/Guardian signature required

Page 6 - Student information (please fill out completely)

Page 7 - (4) Parent/Guardian signatures required

Page 8 - (1) Student and (1) Parent/Guardian signature required

Page 9 - (1) Student and (1) Parent/Guardian signature required

Page 10 - (1) Student and (1) Parent/Guardian signature required

Page 11 - Fill in Student information at the top of the form

MAKING MULTIPLE COPIES???
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Contact the Office of Athletics if you have any questions. (215) 400- 4190

ALL PACKETS SUBMITTED IN ADVANCE WILL BE PRESCREENED BY PARTNERING PHYSICIANS



James Patrick Lynch
Executive Director

O: 215-400-4190
E: jlynch@philasd.org

JUNE 10, 2018

Dear Parent or Guardian:

The School District of Philadelphia (the "School District") offers your child,

_____ (student's name, the "Student")

the opportunity to receive physical and medical screenings and evaluations in connection with his or her participation in interscholastic athletics in the School District and the Pennsylvania Interscholastic Athletic Association (the "PIAA"), including competition in PIAA Division XII, which includes the public, charter and Diocesan schools in Philadelphia, and other PIAA competition throughout the Commonwealth.

The PIAA requires certain physical and medical screenings and evaluations before students may participate in PIAA interscholastic competition. The School District will work with partnering local medical providers to offer these physical and medical screenings and evaluations at no cost to the Student and others.

The School District asks for your consent to permit your child to participate in physical and medical screenings and evaluations offered by the School District and others.

CONSENT AND PERMISSION

I am the parent or guardian of the Student, a minor and a student at

_____, School in the School District.

For myself and the Student, I hereby give permission to the School District to offer and carry out certain physical and medical screenings and evaluations in order to establish the Student's eligibility to participate in PIAA-sponsored athletic competition. I understand that I do not have to give my consent, and that I can make other arrangements, if I want, to provide the necessary physical and medical screenings and evaluations in connection with participation in PIAA-sponsored athletics, including going to a doctor of my own choosing. I also understand that I can and should consult a doctor of my own choosing in the event these physical and medical screenings and evaluations indicate any condition or concern regarding the Student's health. I understand that these are screenings and evaluations only, and not treatment of any medical conditions.

I understand the risks of physical and medical screenings and evaluations, and give my consent and permission after I have considered these risks, which include the possibility that screenings and evaluations may not identify a medical condition.

By signing below, I agree that I understand this Consent and Permission form and that if I have any questions in connection with this form I have had the opportunity to call 215.400.4190, The School District of Philadelphia Division of Athletics to discuss any questions.

Signature of Parent/Guardian

Date

Name of Parent/Guardian (please print or type)

Name _____

Address _____

Telephone _____



For and consideration of screening and medical services to be provided to

Name of Student: _____ Date of Birth: _____,

(“Student”) by the Athlete Health Organization (AHO), and other physicians, nurses and healthcare providers, and any entities employing or affiliated with the forgoing, including, without limitation, the board and its directors of the Athlete Health Organization, J.J. Steingard, MD, Steingard & Testa Associates, Inc., The Children’s Hospital of Philadelphia, Philadelphia Orthopaedic LLC, Roxborough Memorial Hospital, Philadelphia College of Osteopathic Medicine, Thomas Jefferson University Hospitals, Premier Orthopaedic & Sports Medicine Associates, LTD, The Heart Center of Philadelphia, P.C., Wills Eye Hospital, Hahnemann University Hospital, Temple University Hospital, Drexel University, Philadelphia School District, Archdiocese of Philadelphia, The Wells Fargo Center, Admark360, LLC, Jefferson University Physicians, Temple Hospital and physicians, Nemours Hospital and physicians, St Christopher’s Hospital and physicians, Main Line Health System and physicians, Simons Fund, Rothman Institute, Jeffcare Physicians, Excel Physical Therapy, Abington Hospital and physicians, Clinical Neuropsychology Associates, ERT Inc., Methodist Hospital, Einstein Medical Center, all advertisers, sponsors and/or partners of the AHO and the Event, and their respective (collectively referred to as “Releasees”) and intending to be legally bound hereby:

I, (Student)(Or parent or legal guardian if student is not eighteen (18) years of age on this date), **do hereby release and discharge**, and by these presents do for myself, my heirs, executors, administrators, and assigns release and forever discharge Releasees, their agents, servants, successors, assigns, trustee, officers, employees, medical staff, heirs, executors and administrators from any and all actions, causes of action, claims or demands for damages, cost, loss of use, expenses, or consequential damage of any kind whatsoever on account of, or in any way growing out of, including any and all unknown and known damages resulting from, all screening and medical services rendered on **Sunday, June 10, 2018** to Student.

I understand this Release and assume all risk, chance of hazard that is now known, unknown, anticipated, unanticipated, expected or unexpected. No promise or inducement which is not herein expressed has been made to me, and in executing this Release I do not rely upon any statement or representation made by any person, firm, or corporation, hereby released or any agent or any other person representing them or any of them, concerning the nature or extent of the services being rendered. I understand that I am not required to see Releasees and have the right to see a family doctor, pediatrician, or specialist of my own choosing. I also understand and agree to consult a physician of my choice in the event any abnormality in the health of Student is identified.

I understand that this screening event does not in any way establish a patient - doctor relationship; nor does it replace any existing relationship with my personal/family primary care physician. I understand that all medical inquiries regarding my health should be presented to my primary care physician. I understand that this screening does not replace the need for a full physical by my physician or healthcare provider and is intended solely for athletic participation, as required by the PIAA (Pennsylvania Interscholastic Athletic Association).

I hereby grant my specific permission to the AHO, their employees, volunteers, organizers, sponsors, advertisers and assigns to make and/or obtain photographic images of me on the day of the event and to publish, copyright, distribute and/or display photographic images taken of me on the day of the event. I further waive the right to inspect and/or examine all photographs and/or written text to which the images may be applied before use. I also waive any and all rights and claims, including future rights and claims to such photographic images and any interest therein. I hereby release and discharge the above named from any and all liability by virtue of distortion, blurring, alteration, optical illusion, digital scanning and manipulation, and/or use in composite form, whether the same is intentional, or otherwise. I understand that the above named may use any process or procedure resulting in the completion of the finished product for publication, display, copyright or distribution.

In further consideration, the undersigned hereby agrees to save harmless and indemnify the Releasees, their agents, servants, successors, assigns, trustee, officers, employees, medical staffs, heirs, executors and administrators of and from any and all claims, suits, liens and/or expenses arising from this occurrence or from any claim, which may hereafter be presented by anyone for loss and damages as a result of the above mentioned occurrence.

This Release contains the ENTIRE AGREEMENT between the parties hereto, and the terms of this release are contractual and not a mere recital.

I further state that I have carefully read the forgoing Release, know the contents thereof, and sign the same as my own free act. Signed, sealed and delivered this, _____ day of _____, 2018.

Student age 18 or Student’s Parent/Guardian _____

Telephone Number:



**PIAA COMPREHENSIVE INITIAL
PRE-PARTICIPATION PHYSICAL EVALUATION**



INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the current spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # () _____ Parent/Guardian Current Cellular Phone # () _____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

Student's Allergies _____

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware _____

Student's Prescription Medications and conditions of which they are being prescribed _____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date ____/____/____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date ____/____/____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date ____/____/____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____ Date ____/____/____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature _____ Date ____/____/____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
 - The right equipment for the sport, position, or activity;
 - Worn correctly and the correct size and fit; and
 - Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date ____ / ____ / ____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____ Date ____ / ____ / ____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete	Print Student-Athlete's Name	Date ___/___/___
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date ___/___/___

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

	Yes	No		Yes	No																
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
9. Has a doctor ever told you that you have (check all that apply):			CONCUSSION OR TRAUMATIC BRAIN INJURY																		
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur			31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you experience dizziness and/or headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>																
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you unhappy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;">Head</td> <td style="width: 12.5%;">Neck</td> <td style="width: 12.5%;">Shoulder</td> <td style="width: 12.5%;">Upper arm</td> <td style="width: 12.5%;">Elbow</td> <td style="width: 12.5%;">Forearm</td> <td style="width: 12.5%;">Hand/ Fingers</td> <td style="width: 12.5%;">Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest														
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes														
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>													
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>													
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>				48. How old were you when you had your first menstrual period?	_____	_____													
						49. How many periods have you had in the last 12 months?	_____	_____													
						50. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>													

#s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____