Carnegie Medical Clinic

HEALTHCARE

Parental Consent Form

School Sports Physical

I, _____, parent or legal guardian of
(parent/guardian name)

_____, born on_____, do
(student athlete's name) (student athlete's date of birth)

hereby authorize a sports/school physical to be performed on
_____/_____/_____
(date of sports physical exam)

by the providers of this clinic, for my child, a student at_____school.
(Name of School)

I understand that this is a pre-season sports physical screening exam. It is not a comprehensive exam and it is not intended to provide treatment nor to create a physician/patient relationship. I understand that athletic participation comes with the risk of injury. This screening exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

I certify that I am the parent/legal guardian for this athlete/minor. I understand the information above and by signature grant consent.

_____ _____/_____/_____

Signature of Parent/Guardian Date

(_____) _____ - _____

Parent/Guardian Day Time Contact Number

(_____) _____ - _____

Parent/Guardian Cell Phone Number

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION
PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

PLEASE PRINT

UPDATED APRIL 2021

NAME:_____GENDER_____AGE_____DATE OF BIRTH_____

GRADE_____SCHOOL_____ACTIVITIES_____

ADDRESS_____

PHYSICIAN'S NAME_____PHONE_____

EMERGENCY CONTACT_____RELATIONSHIP_____

PHONE OF EMERGENCY CONTACT_____

PLEASE EXPLAIN ALL YES ANSWERS ON A SEPARATE SHEET

	YES	NO
1. Have you had a medical illness or injury since your last check up or physical?		
2. Have you ever been hospitalized overnight?		
3. Have you ever had surgery?		
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
7. Have you ever had a rash or hives develop during or after exercise?		
8. Have you ever passed out during or after exercise?		
9. Have you ever been dizzy during or after exercise?		
10. Have you ever had chest pain during or after exercise?		
11. Do you get tired more quickly than your friends do during exercise?		
12. Have you ever had racing of your heart or skipped heartbeats?		
13. Have you had high blood pressure or high cholesterol?		
14. Have you ever been told you have a heart murmur?		
15. Has any family member or relative died of heart problems or of sudden death before age 50?		
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
17. Has a physician ever denied or restricted your participation in activities for any heart problems?		
18. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
19. Have you ever had a head injury or concussion?		
20. Have you ever been knocked out, become unconscious, or lost your memory?		
21. Have you ever had a seizure?		
22. Do you have frequent or severe headaches?		

	YES	NO
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
24. Have you ever become ill from exercising in the heat?		
25. Have you ever tested positive for COVID?		
26. Do you cough, wheeze, or have trouble breathing during or after activity?		
27. Do you have asthma?		
28. Do you have seasonal allergies that require medical treatment?		
29. Do you or does someone in your family have sickle cell trait or disease?		
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
31. Have you had any problems with your eyes or vision?		
32. Do you wear glasses, contacts, or protective eyewear?		
33. Have you ever had a sprain, strain, or swelling after injury?		
34. Have you broken or fractured any bones or dislocated any joints?		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? 36. If yes, circle appropriate affected area and explain below:		
37. Do you want to weigh more or less than you do now?		
38. Do you lose weight regularly to meet weight requirements for your activity?		
39. Do you feel stressed?		
40. Record the dates of your most recent immunizations for: Tetanus_____Measles_____ Hepatitis_____Chickenpox_____		

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury with participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, athletic trainers or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to OSSAA in connection with any investigation or inquiry concerning the student's eligibility to participate an/or any possible violation of OSSAA rules. OSSAA will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

SIGNATURE OF GUARDIAN_____SIGNATURE OF STUDENT_____

PREPARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT

DATE OF EXAM _____

Name_____ Date of Birth_____

Height_____ Weight_____ Body fat (optional)_____% Pulse_____ BP_____/_____ Color Blind Yes No (circle one)

Vision: R 20/_____ L 20/_____

Corrected Y / N Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

( ) Cleared

( ) Cleared after completing evaluation/rehabilitation for:_____

( ) Not cleared for: _____

Reason:_____

Recommendations: _____

Printed name of Examiner_____

Address:_____ Phone:_____

Date:_____ Signature:_____