To be completed for students participating in *all* NSAA activities.

NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)
Student and Parent Consent Form

School Year: 20_____-20_____ Member School: _____
Name of Student: _____
Date of Birth: _____ Place of Birth: _____

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above named Student and are collectively referred to as "Parent".

The Parent and Student hereby:
(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;

(2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; and, (d) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities' rules of the NSAA member school for which the Student is participating; and,

(4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

DATED this ____ day of _____, _____.

_____ _____
Name of Student [Print Name] Student Signature

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for _____[insert student name] to practice and compete for the above named high school in activities approved by the NSAA, **except those crossed out below:**

[redacted]	[redacted]	[redacted]	Play Production	Basketball	[redacted]
Track	Football	Speech	Cross County	[redacted]	Volleyball
Music	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

DATED this ____ day of _____, _____.

_____ _____
Parent [Print Name] Parent Signature
Revised June 2016

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

Parent or Legal Guardian Signature _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____/____ (____/____) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Nebraska Law requires a physical examination prior to entrance into kindergarten, 7th grade, and all students transferring into the State of Nebraska.

Name of Student (Last / First / Middle) Birthdate Age Grade School

Name of Parent/Guardian Address Phone / Cell Number

Family Provider City Family Dentist City

IMMUNIZATIONS

DtaP / DTP/Tdap / DT/Td #1_____ #2_____ #3_____ #4_____ #5_____ #6_____

Polio (IPV/OPV) #1_____ #2_____ #3_____ #4_____ #5_____

HIB #1_____ #2_____ #3_____ #4_____

PCV/Prevnar #1_____ #2_____ #3_____ #4_____

MMR / MMRV #1_____ #2_____

Hepatitis B (Hep B or HBV) #1_____ #2_____ #3_____ #4_____

Hepatitis A #1_____ #2_____ Menactra (Meningitis Vaccine) #1_____ #2_____

RotaTeq (Rota Virus Vaccine)) #1_____ #2_____ #3_____

Varicella (Chickenpox Vaccine) #1_____ #2_____ Year of Chickenpox Disease _____

HPV/Gardisil (Females Only) #1_____ #2_____ #3_____

Other Immunizations_____

HEALTH HISTORY (Please check Yes or No for each)

Bowel / Bladder Problems ☐ Yes ☐ No Asthma ☐ Yes ☐ No Meds _____

Kidney Problems ☐ Yes ☐ No Asthma Action Plan ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Meds _____

ADHD ☐ Yes ☐ No Meds _____

Allergy to meds ☐ Yes ☐ No Explain Reaction_____

Allergy to food ☐ Yes ☐ No Explain Reaction_____

Other allergies ☐ Yes ☐ No Explain Reaction_____

Diabetes ☐ Yes ☐ No Meds _____

Seizures/Convulsions ☐ Yes ☐ No Explain / **Meds** _____

Concussions / Dates ☐ Yes ☐ No Explain / **Meds** _____

Additional Medications ☐ Yes ☐ No Explain / **Meds** _____

Family History of Early Cardiac Death Explain _____

Psychiatric/Behavior/Emotional Concerns Explain _____

Surgery / Dates Explain _____

Other Health Problems Explain _____

Additional Information _____

I verify that the above information is correct to the best of my knowledge.

_____

Parent / Guardian Signature *Date*

OVER

Name of Student (Last / First / Middle) _____ Grade _____ School _____

PHYSICAL EXAMINATION

(to be completed by a physician, physician's assistant. or nurse practitioner)

Height _____ Neck _____ Mouth/Teeth _____

Weight _____ Lungs _____ Abdomen _____

BP _____ Eyes _____ Spine _____

Pulse _____ Ears _____ Scoliosis _____

Heart _____ Skin _____ Extremities _____

Urinalysis results _____ Hgb/Hct results _____

Hearing Test (please circle) Normal / Abnormal

Left Ear	Right Ear	Hz
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	400

Comments _____

List any additional information regarding this student that may affect safety or optimal performance in school: _____

_____

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time (includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska) [NE revised Statute 79-214]

Vision Test (please circle) Normal / Abnormal

Required Tests	Pass	Fail	Recommendations	Vision	Glasses / Contacts / Neither
Amblyopia				Right eye @ Far (20')	20 / _____ aided / unaided
Strabismus				Left eye @ Far (20')	20 / _____ aided / unaided
Internal Eye Health					
External Eye Health				Right eye @ Near (16")	20 / _____ aided / unaided
Visual Acuity				Left eye @ Near (16")	20 / _____ aided / unaided

Provider's Signature _____ *Date* _____

DENTAL EXAMINATION *(optional)*

Is oral hygiene adequate Yes / No Number of fillings present_____ Number of restorations needed_____

Recommendations: _____

_____

Dentist's Signature _____ *Date* _____

WAIVER of PHYSICAL and/or VISION EXAMINATION

I, the parent/guardian of _____ *do not feel it necessary for he/she to*
Name of Child

a physical and/or vision examination and therefore exercise my right to waiver his/her physical and/or vision examination.

Parent/Guardian Signature _____ *Date* _____

OVER