North Coast Schools' Insurance Group

HISTORY FORM

Preparticipation Physical Evaluation

Physicians may use the Child Health and Disability Prevention Pre-participation Physical Evaluation History form instead of the JPA 24.

DATE OF EXAM _____

Name _____ Sex ____ Age ____ Date of Birth _____
Grade ____ School _____ Sport(s) _____
Address _____ Phone _____
Personal Physician _____
In Case of Emergency, Contact _____
Name _____ Relationship _____ Phone (H) _____ (W) _____

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
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:		

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?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period?	_____	
49. 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 _____

North Coast Schools' Insurance Group

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ___/___(___/___, ___/___)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

PHYSICIAN REMINDERS

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

Notes:

	NORMAL	ABNORMAL FINDINGS	INITIALS *
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)* *			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

* Multiple-examiner set-up only.
* * Having a third party present is recommended for the genitourinary examination.

Notes: _____

Sports participation: Approved: _____ Conditional: _____ Denied: _____

Name of physician (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician _____, MD, DO, ND, NP or PA

North Coast Schools' Insurance Group

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

In order for the student athlete to be able to participate in sports, minimally, the completed JPA 24, page 3 needs to be received by the school.

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 contra-indications 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, DO, ND, NPor, PA

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

DEL NORTE COUNTY UNIFIED SCHOOL DISTRICT

301 West Washington Blvd., Crescent City, CA 95531
707-464-6141

CODE OF CONDUCT FOR ATHLETICS, EXTRA CURRICULAR AND COCURRICULAR ACTIVITIES GRADES 6-12

This form must be signed by a parent and student and returned to the coach or advisor before the student may participate in practice or performance.

Students volunteer to participate on athletic teams as well as other competitive or performing groups. They are expected to maintain high standards of conduct at all times. A good physical and mental condition is necessary for performance in athletics or activities. The protection of health and safety of all students is also a major concern.

If a student is guilty of violating either of the following rules at school or at a school activity, the result will be dismissal from the team for the remainder of the season. In the case of performing activities, students will be dismissed for 9 weeks from the date of the infraction:

1. Use or possession of illegal drugs or alcohol.
2. Involvement in a crime that has a victim.

An appropriate punishment will be assigned by each coach or advisor for violation of any of the following:

1. Use or possession of tobacco.
2. Practice cuts.
3. Practice tardiness.

Coaches or advisors may impose a curfew or dress standards. In either case, participants and parents/guardians will be informed in writing.

Our rules are not intended to control students' lives away from school, but students must realize that our programs and their activity are judged by the public on the basis of appearance and behavior. Our program of sports and activities can only prosper when we create and maintain a positive image.

Students are prohibited from participating in a school activity while on suspension until the day after their suspension is complete.

I have read the above and agree to participate under these rules.

Student Signature_____

Parent/Guardian Signature_____

Date:_____

DEL NORTE COUNTY UNIFIED SCHOOL DISTRICT
Authorization To Consent for Treatment
And
Transportation of a Minor

I, We the undersigned, parent(s)/Guardian(s) of:

_____, A minor, do hereby authorize,

_____, as agent(s) for the undersigned to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until _____.
Unless sooner revoked in writing and delivered to aforementioned agent(s).

Parent/Guardian Signature _____

Date _____ Home Phone _____ Work Phone _____

MEDICAL INFORMATION

Name of Physician: _____

List any medications the child is taking:

_____

_____

_____

North Coast Schools Insurance Group JPA 5

Acknowledgement and Assumption of Potential Risk

Voluntary Sports Activity

*(Student Name)*_____ has my permission to participate in the activity listed below. **I fully understand the following:**

(Circle appropriate activities) Football, Basketball, Volleyball, Cheerleading, Track & Field, Baseball, Soccer, Wrestling, Tennis, Cross Country, Golf, Other _____ by its very nature, poses some inherent risk of a participant being seriously injured. These injuries could include, but are not limited to, the following:

1. Sprains/strains
2. Fractured bones
3. Cuts/abrasions
4. Unconsciousness
5. Paralysis
6. Disfigurement
7. Head injuries
8. Loss of eyesight
9. Death

All participants in this activity should understand that the participation is voluntary and is not required by the school district.

I understand and acknowledge that in order to participate in these activities, I and my son/daughter agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities.

I understand, acknowledge, and agree that the _____ School District, its employees, officers, agents, or volunteers, shall not be liable for any injury suffered by my son/ daughter which is incident to and/or associated with preparing for and/or participating in this activity.

List any medical conditions, allergies or other limiting factors:

_____

_____

* Medical examination release has been completed: Yes No *(Circle one)*
Family physician name: _____ Phone # _____

Health insurance/MEDI-CAL per Education Code 32220-32224: Yes No *(Circle one)*
Plan name and number: _____

In the event of illness or injury, I do hereby consent to medical/hospital treatments that are determined necessary in the best judgement of the attending physicians or dentists. I acknowledge that I have carefully read this **Voluntary Sports Activities Form** and that I understand and agree to its terms.

_____ _____
Parent/legal guardian (if under 18) *Date*

_____ _____
Student signature *Date*

* Medical exams recommended for all playing field participants (includes cheerleaders); however, they are only *required* for high school. Band members, team managers and ROP students—i.e., non-playing field participants—are exempt.