

# **ATHLETIC DEPARTMENT**

## **FORMS**

To be returned to;

Head Coach or Athletic Director

# Oliver Ames Tigers

## Receipt – Code of Conduct Risk of Injury Release of Health Information

I have read the Student-Athlete Handbook and agree that my child and I will abide by all of its provisions. My child has my permission to participate in the athletic activities at Oliver Ames High School and Easton Junior High School.

- This includes all practices, contests and traveling sponsored and supervised by the Easton Public Schools.
- I, \_\_\_\_\_, the undersigned (father, mother, legal guardian) of \_\_\_\_\_, (son/daughter), a minor, do hereby consent to his/her participation in voluntary athletic programs and do forever RELEASE, acquit, discharge, and covenant to hold harmless the Town of Easton and the Easton Public Schools from any and all actions, causes of action and claims on account of, or in any way growing out of, directly and indirectly, all known and unknown personal injuries or property damage which I may now or hereafter have as the parent of said minor, and also all claims of right of action for damages which said minor has or hereafter may acquire, either before or after he/she has reached his/her age of majority resulting from his/her participation in the Easton Public Schools athletic programs.
- I permit the school nurse to share all health related information with the athletic trainer as appropriate.
- I permit the athletic trainer to share necessary health related information with my son's/daughter's coaches.

***Sports: (please circle the sports your son/daughter may be interested in participating)***

Fall Sports

Football  
Field Hockey  
Cross Country  
Soccer  
Cheerleading  
Golf  
Volleyball

Winter Sports

Basketball  
Ice Hockey  
Track & Field  
Skiing  
Swimming & Diving  
Cheerleading  
Wrestling

Spring Sports

Baseball  
Softball  
Track & Field  
Lacrosse  
Tennis

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student-Athlete Name (Please Print): \_\_\_\_\_

# Medical Information Card

**General Information (Please Print):**

Student-Athlete: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Medical Information:**

Medical Illnesses (asthma, seizures, heart condition): \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Emergency Contact:**

Parent/Guardian(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I hereby give consent for my child to participate in Oliver Ames High School/Junior High School athletic programs for the fall, winter and spring seasons. I am delegating authority in advance for my child to receive any necessary healthcare treatment, including first aid, diagnostic procedures and medical treatment, that may be provided by treating physicians, nurses, EMT's and the athletic trainers. In the event I cannot be reached in an emergency, I hereby give permission for my child to be transported to receive necessary medical/surgical treatment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Sports: (please circle the sports your son/daughter may be interested in participating)**

Fall Sports

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Field Hockey  
Cross Country  
Soccer  
Cheerleading  
Golf  
Volleyball

Winter Sports

Basketball  
Ice Hockey  
Track & Field  
Skiing  
Swimming & Diving  
Cheerleading  
Wrestling

Spring Sports

Baseball  
Softball  
Track & Field  
Lacrosse  
Tennis

# OLIVER AMES TIGERS SPORTS PHYSICAL

**This side should be filled out and signed by a parent/guardian. Please Print Legibly**

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Grade: \_\_\_\_\_

Sport(s): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

## **PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY**

- |     |    |     |   |
|-----|----|-----|---|
| Yes | No | 1.  | Do you or have you ever had an ongoing or chronic illness?  |
| Yes | No | 2.  | Have you ever been hospitalized overnight?  |
| Yes | No | 3.  | Have you ever had surgery?  |
| Yes | No | 4.  | Do you have a single organ? If yes, which one? (Example: 1 kidney)  |
| Yes | No | 5.  | Are you currently taking any prescription or over the counter medications?  |
| Yes | No | 6.  | Do you have any allergies to food, medication, stinging insects or pollen?  |
| Yes | No | 6a  | If yes, do you carry an epipen?   |
| Yes | No | 7.  | Have you ever been dizzy, lightheaded or fainted during or after activity?  |
| Yes | No | 8.  | Have you ever been told you have a heart murmur?  |
| Yes | No | 9.  | Do you or any family member have a history of heart problems?   |
| Yes | No | 10. | Have you ever had a severe viral infection (mononucleosis)? If so, When?  |
| Yes | No | 11. | Have you ever had a concussion? Or had your bell rung? If so, When?   |
| Yes | No | 12. | Have you ever been knocked out, become unconscious or lost your memory?   |
| Yes | No | 13. | Do you have frequent or sever headaches?  |
| Yes | No | 14. | Have you ever had a seizure? When? Are you under Doctors care for them?   |
| Yes | No | 15. | Do you have diabetes? If yes, are you insulin dependent?  |
| Yes | No | 16. | Have you ever had an injury to you back that required you to refrain from activity?   |
| Yes | No | 17. | Do you have scoliosis?  |
| Yes | No | 18. | Have you ever had numbness or tingling in your arms, hands, legs, or feet?  |
| Yes | No | 19. | Have you ever had a stinger, burner, or a pinched nerve?  |
| Yes | No | 20. | Do you cough, wheeze or have trouble breathing during or after activity?  |
| Yes | No | 21. | Do you use an inhaler?  |
| Yes | No | 22. | Have you ever become ill from activity in the heat?   |
| Yes | No | 23. | Do you use any special protective/corrective equipment for your sport, such as orthotics, any type of brace or neck roll, etc.? |
| Yes | No | 24. | Do you wear glasses or contacts during activities?  |
| Yes | No | 25. | Have you ever broken or fractured a bone or dislocated a joint?   |
| Yes | No | 26. | Have you ever had a knee injury that produced immediate and/or severe swelling?   |
| Yes | No | 27. | Have you ever sprained an ankle causing discolor or that forced you to use crutches?  |
| Yes | No | 28. | Do you have problems with shin splints?   |

**PLEASE WRITE THE # AND THEN EXPLAIN ALL OF THE "YES" ANSWERS BELOW**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**OLIVER AMES TIGERS PHYSICIAN'S EXAMINATION**  
**THIS SIDE OF THE SPORTS PHYSICAL IS TO BE FILLED OUT BY YOUR DOCTOR**

Name: \_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_

Pulse: \_\_\_\_\_ Vision: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS
Hearing/Ears	_____	_____
Vision/Eyes	_____	Contacts/Glasses_Y_N_____
Nose/Throat	_____	_____
Mouth/Teeth	_____	_____
Neck	_____	_____
Head	_____	Concussion_Y_N__When?_____
Heart	_____	Any known cardiac/heart condition_Y_N_____
Lungs	_____	HX of Asthma_Y_N____Inhaler_Y_N_____
Abdomen	_____	_____
Elbow/Wrist/Hand	_____	_____
Shoulders	_____	_____
Spine/Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Ankle/Foot	_____	_____
Skin/Lymphatics	_____	_____
Genitalia	_____	_____
Neurological	_____	_____

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_

I hereby certify that this athlete is:

\_\_\_\_\_ Cleared for full participation in athletics @ Oliver Ames High School & Easton Junior High School

\_\_\_\_\_ Cleared after completing further evaluation for the following: \_\_\_\_\_

\_\_\_\_\_ Denied participation in athletics @ Oliver Ames High School & Easton Junior High School for the following reason(s): \_\_\_\_\_

\_\_\_\_\_  
 (Please Print) **Physicians Name**

\_\_\_\_\_  
**Physicians Signature**

# Easton Public Schools

## GENERAL RELEASE – MINOR CONSENT FOR MEDICAL TREATMENT

I, \_\_\_\_\_ as parent/guardian of  
\_\_\_\_\_, a minor child, do hereby consent to

his/her participation in the voluntary \_\_\_\_\_ activity offered by the Town of Easton, and do forever release, discharge, indemnify and hold harmless the Town of Easton from any and all actions, causes of actions, and claims for personal injury(ies) or damages on account of, or in any way arising out of my minor child's participation in the program, which I, as the parent or guardian of the minor child may have now or in the future. I further release, discharge, indemnify and hold harmless the Town of Easton from any claims or rights of action for personal injury(ies) or damages which said minor has or hereafter may acquire, either before or after he/she has reached his/her majority resulting from or in any way arising out of his/her participation in the above-referenced voluntary activity.

As parent/guardian of the above-named minor child, in any absence, I hereby authorize the Town of Easton to transport the minor child to a hospital or to place him/her in the care of an ambulance attendant(s) for transportation to the hospital and give my consent for emergency medical care by a licensed Doctor of Medicine or Dentistry as may be warranted to preserve the well being of my child.

Signature of Parent/Guardian: \_\_\_\_\_

Dated: \_\_\_\_\_

Medical Insurance Policy No: \_\_\_\_\_

# Easton Public Schools

## GENERAL RELEASE

(Students 18 years or Over)

### CONSENT FOR MEDICAL TREATMENT

I, \_\_\_\_\_ do hereby consent to

participation in the voluntary \_\_\_\_\_ activity offered by the Town of Easton, and do forever release, discharge, indemnify and hold harmless the Town of Easton from any and all actions, causes of actions, and claims for personal injury(ies) or damages on account of, or in any way arising out of my participation in the program, which I may have now or in the future. I further release, discharge, indemnify and hold harmless the Town of Easton from any claims or rights of action for personal injury(ies) or damages which I have or hereafter may acquire, resulting from or in any way arising out of my participation in the above-referenced voluntary activity.

I hereby authorize the Town of Easton to transport me to a hospital or to place me in the care of an ambulance attendant(s) for transportation to the hospital and give my consent for emergency medical care by a licensed Doctor of Medicine or Dentistry as may be warranted to preserve my well being.

Signature of Student: \_\_\_\_\_

Dated: \_\_\_\_\_

Medical Insurance Policy No: \_\_\_\_\_