

\_\_\_\_\_  
Last Name                                      First Name                                      Sport(s) interested in playing

**ROBERTSVILLE MIDDLE SCHOOL**  
**SPORTS INFORMATION AND PERMISSION FORMS**

**PARENTAL CONSENT & EMERGENCY TREATMENT**

I/We give consent for the above named student to represent Robertsville Middle School in Athletics. It is understood that such activity involves the potential for injury. It is acknowledged that even with competent coaching, the use and care of good equipment, and the observance of rules, injuries are still a possibility. On rare occasions these injuries can be severe and lead to a disabling condition or death.

Permission is granted to Robertsville Middle School for the physicians, coaches and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonable and necessary to protect the health and well being of the above named individual.

**PARENTS:** Many hospitals and doctors will not treat a child without parental consent (unless a matter of life or death). It is required that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

I have read and understand that I accept financial responsibility for any injury not covered by the school accident insurance or my hospitalization insurance. I further understand that it will be my responsibility to file claims for injuries received.

I/We have read the Field Trip policy with our student. Student will abide by all **RMS Field Trip rules**, making up any **class work missed**. It is understood that I will be **responsible for the loss or damage to personal property of others or injury to another person** caused by the above named student. It is also understood that the City of Oak Ridge and the Oak Ridge School System is responsible only for injuries that result from the negligence of their staff. Robertsville Middle School will **not be responsible** for the liability or insurance coverage of private or public carriers.

**EMERGENCY INFORMATION**

**Student Name:** \_\_\_\_\_ **Student Cell #:** \_\_\_\_\_

**Upcoming Grade** 17 **School Year:** \_\_\_\_\_ **Sex:** M \_\_\_ F \_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**1<sup>st</sup> Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Home #:** \_\_\_\_\_

\_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Employed by:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**2<sup>nd</sup> Guardian's Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Home #:** \_\_\_\_\_

\_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Employed by:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_  
**Parent / Guardian Signature (Consent statement authorization to treat)**

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

\_\_\_\_\_  
**Student Signature**

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

**Insurance Coverage Waiver**

In order to participate in interscholastic athletics at Robertsville Middle School, each participant must be covered by an insurance policy; or Robertsville Middle School must have on file a statement signed by the parent/guardian indicating coverage under another health or hospitalization insurance policy. **Oak Ridge Schools do not carry a blanket student accident insurance policy.** You must apply for coverage if your child is not covered under another policy.

- \_\_\_ I am not covered under any other health or accident policy.
- \_\_\_ I am covered by another health insurance policy (such as Blue Cross-Blue Shield).

**Name of Company:** \_\_\_\_\_

**Policy or Group #:** \_\_\_\_\_

I understand that I accept financial responsibility for any injury not covered by the school accident or my hospitalization insurance. I further understand that it will be my responsibility to file claims for injuries received.

*CoverKids offers free health coverage to uninsured children based on family income. There are two easy ways to apply. Visit [www.coverkids.com](http://www.coverkids.com) to apply online or call 1-866-620-8864 to request an application.*

*Only interscholastic football for grades 9, 10, 11, and 12 requires the special premium for the fall and spring football program. All other sports are covered under the regular accident policy when the student has paid the premium.*

**FIELD TRIPS- ATHLETICS**

Athletic trips are treated as any school-sponsored field trip. A student must abide by all **RMS Field Trip rules**, including any additional rules deemed necessary by the coach. Serious violations, i.e., theft, vandalism, alcohol, will result in school disciplinary action, including being banned from future field trips. A field trip violation could affect a student remaining on a team.

It is understood that on any authorized field trip, the student has the privilege and responsibility for making up any **class work missed**.

If the student behaves in a manner unsuitable for the coaches or chaperone, I agree to accept a **collect long distance call and to provide transportation** for their return to Oak Ridge.

Robertsville Middle School will **not be responsible** for the liability or insurance coverage of private or public carriers.

**2017-2018 Pre-Participation Medical Evaluation Form**  
**To be completed by Student & Parent/Guardian**

**Personal History**

Name	Sex	Age	Date of Birth
Sports		School	<u>Upcoming Grade 2017</u>

Personal Physician(s)	Address	Phone #
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Have you ever had a pre-participation physical before?  Yes  No Where: \_\_\_\_\_

<b>GENERAL QUESTIONS</b>	<b>YES</b>	<b>NO</b>
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 circle below: • Asthma • Anemia • Diabetes • Infections Other: _____		
3. Have you ever been hospitalized or had surgery?		
4. Are you presently taking any medications or pills?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>YES</b>	<b>NO</b>
5. Have you ever passed out or nearly passed out DURING or AFTER exercise or in the heat?		
6. Have you ever had chest pain during or after exercise?		
7. Have you ever had racing or skipped heart beats?		
8. Has a doctor ever told you that you have any heart problems? If so, circle all that apply below: • 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? (ECG/EKG, echocardiogram)		
10. Have you ever had an unexplained seizure?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>YES</b>	<b>NO</b>
11. Has anyone in your family died or had heart problems before age 50?		
<b>BONE AND JOINT QUESTIONS</b>	<b>YES</b>	<b>NO</b>
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints? Check all that apply. _ Head _ Shoulder _ Thigh _ Neck _ Elbow _ Knee _ Chest _ Forearm _ Shin/Calf _ Back _ Wrist _ Ankle _ Hip _ Hand _ Foot		
13. Do you use any special equipment?		
<b>MEDICAL QUESTIONS</b>	<b>YES</b>	<b>NO</b>
14. Do you have trouble breathing, use an inhaler or taken asthma medicine?		
15. Do you have damage or absence of any paired organs? kidney, testicles, eyes etc?		
16. Have you had infectious mononucleosis?		
17. Do you have any skin problems? Rashes, itching, acne?		
18. Have you ever been knocked out or unconscious?		
19. Have you ever had a head injury?		
20. Do you ever had a seizure?		
21. Do you have headaches with exercise?		
22. Have you ever had a stinger, burner or pinched nerve?		
23. Have you ever had heat or muscle cramps?		
24. Have you or a family member had a history of sickle cell?		
25. Do you wear glasses, contact lenses, protective eyewear, such as goggles or a face shield?		
26. Are you on a special diet or do you avoid certain types of foods?		
27. Have you ever had an eating disorder?		
28. When was your last tetanus shot?		
29. When was your last measles immunization?		
<b>FEMALES ONLY</b>	<b>YES</b>	<b>NO</b>
30. How old were you when you had your first menstrual period?		
31. When was your last menstrual period?		
32. What was the longest time between periods last year?		

**Explain 'Yes' answers here**

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
**STUDENT**

Sport(s) interested in playing \_\_\_\_\_

**TMA / TSSAA Pre-Participation Medical Evaluation Form**

To be completed by physician

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: \_\_\_ Yes \_\_\_ No Pupils: \_\_\_\_\_

	Normal	Abnormal Findings
Ears / Nose / Throat		
Chest / Lungs		
Skin / Lymphatics		
Heart		
Abdominals		
Genitalia / Hernia		

**Musculoskeletal Examination**

	Normal	Abnormal Findings
Neck / Back		
Upper Extremities		
Lower Extremities		
Flexibility		

**Optional Lab:** Urine Sugar \_\_\_\_\_  
 Urine Protein \_\_\_\_\_  
 Urine Hematest \_\_\_\_\_

**Official Recommendation**

A. Based on the data gathered from this exam, this athlete \_\_\_ **May** \_\_\_ **May Not** compete in athletics.

B. Prior to participation, treatment or follow-up on the following is recommended:

\_\_\_\_\_

C. Recommend further consultation with: \_\_\_\_\_

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# ROBERTSVILLE MIDDLE SCHOOL

## Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: \_\_\_\_\_

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

After reading the information sheet, I am aware of the following information:

Student Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a <i>health care provider*</i> to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

\* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

\_\_\_\_\_  
Signature of Student-Athlete Date

\_\_\_\_\_  
Signature of Parent/Legal guardian Date

**Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form**

**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 doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. 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?**

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

**Are there warning signs?**

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

- Fainting or seizures during exercise
- Unexplained shortness of breath
- Dizziness
- Extreme fatigue
- Chest pains
- Racing heart

These symptoms can be unclear in athletes, since people often 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 experience SCA die from it.

**Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act**

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

All youth athletes and their parents or guardians 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.

*Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013*

The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:

- (i) Unexplained shortness of breath;
- (ii) Chest pains;
- (iii) Dizziness
- (iv) Racing heart rate; or
- (v) Extreme fatigue; and

Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

***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