PERMISSION SLIP and RELEASE OF LIABILITY

For Emmanuel Christian School Athletics

Please fill out the permission slip (below) and return it with your student the next time he or she attends school.

The slips MUST be filled out COMPLETELY and IN INK! Without a completed permission slip, we will be unable to allow your student to participate!

STUDENT NAME: _____ DATE:_____
(Please print neatly)

ADDRESS: _____CITY:_____ ZIP:_____

WAIVER OF LIABILITY:

I give permission for my above-named student to participate in **Emmanuel Christian School's Athletic Program.** I recognize that participation in an event of this nature may involve recreational, athletic, sporting, interaction with other students and adults, or other activities (including, but not limited to: practices, scrimmages, games, overnight tournaments, consumption of snacks/pizza/hot dogs/hamburgers).

These activities may be hazardous or dangerous. I voluntarily elect to participate in the activities and assume the risks of injury or harm that might result from participation. I recognize that such activities may cause injury. Therefore, I am, for my student, myself, my heirs, executor and/or administrator, remising and releasing and forever discharging the Emmanuel Baptist Temple/Emmanuel Christian School of Hagerstown, Maryland and all of its affiliated entities, officers, agents, servants, volunteers, and employees, acting officially or otherwise, from any and all injury to me (or my minor), damage (including property damage to any of my belongings), loss or death which may occur from any cause including, but not limited to, any accident and/or occurrence while participating individually or with others in any or related activities sponsored in whole or in part by the Emmanuel Baptist Temple/Emmanuel Christian School.

I also authorize Emmanuel Baptist Temple/Emmanuel Christian School to transport my child to and from activities that may take place away from Emmanuel Baptist Temple/Emmanuel Christian School and out of the state of Maryland. This release will also cover risks associated with vehicular accidents.

_____

Signature Date

_____

Printed Name Relationship to Student

CONSENT TO TREAT:

Being the parent or legal guardian of _____ whose birth date is _____, I _____ do consent to any x-ray, anesthetic, medical, surgical or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as a parent or legal guardian, I am responsible for the healthcare decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

PERSONAL HEALTH INSURANCE COMPANY: _____

PHONE#_____Policy#_____

_____

Names of PARENTS or LEGAL GUARDIANS Phone Signature

_____

Name of ALTERNATE PERSON to contact in case of Emergency Phone

Please list any medical or physical limitations below. Include allergies to medication and food.

Medical and/or physical limitations:_____

_____

_____

Allergies to medicine and/or food: _____

_____

_____

Figure 4

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Concussion Awareness
Parent/Student-Athlete Acknowledgement Statement

I _____, the parent/guardian of _____,
Parent/Guardian — Name of Student-Athlete

acknowledge that I have received information on all of the following:

- **The definition of a concussion**
- **The signs and symptoms of a concussion to observe for or that may be reported by my athlete**
- **How to help my athlete prevent a concussion**
- **What to do if I think my athlete has a concussion, specifically, to seek medical attention right away, keep my athlete out of play, tell the coach about a recent concussion, and report any concussion and/or symptoms to the school nurse.**

Parent/Guardian_____ Parent/Guardian_____ Date _____
PRINT NAME — SIGNATURE

Student Athlete_____ Student Athlete_____ Date _____
PRINT NAME — SIGNATURE

It's better to miss one game than the whole season.

For more information visit: **www.cdc.gov/Concussion**.

Figure 5

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, prior to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student Information

Name:

Grade:

Sport(s):

Home Address:

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_____ No_____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes_____ No_____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_____ No_____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion:

Parent/Guardian: Name: _____(Please print)

Signature/Date _____

Student Athlete: Signature/Date _____

Pre-Participation Physical Evaluation

(This page to be completed by student and parent/guardian)

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School Emmanuel Christian School Sports(s) _____

Address 16221 National Pike Hagerstown, MD 21740

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?		
Do you have an ongoing or chronic illness?	Y	N
2. Have you ever been hospitalized overnight?	Y	N
Have you ever had surgery?	Y	N
3. Are you currently taking any prescription or nonprescription (over–the-counter) medications or pills or using an inhaler?	Y	N
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Y	N
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	Y	N
Have you ever had a rash or hives develop during or after exercise?	Y	N
5. Have you ever passed out during or after exercise?	Y	N
Have you ever been dizzy during or after exercise?	Y	N
Have you ever had chest pain during or after exercise?	Y	N
Do you get tired more quickly than your friends do during exercise?	Y	N
Have you ever had racing of your heart or skipped heartbeats?	Y	N
Have you had high blood pressure or high cholesterol?	Y	N
Have you ever been told you have a heart murmur?	Y	N
Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	Y	N
Has a physician ever denied or restricted your participation in sports for any heart problems?	Y	N
6. Do you have any current skin problems (for example, itiching, rashes, acne, warts, fungus, or blisters)?	Y	N
7. Have you ever had a head injury or concussion?	Y	N
Have you ever been knocked out, become unconscious, or lost your memory?	Y	N
Have you ever had a seizure?	Y	N
Do you have frequent or severe headaches?	Y	N
Have you ever had numbness or tingling in your arms hands, legs, or feet?	Y	N
Have you ever had a stinger, burner, or pinched nerve?	Y	N
8. Have you ever become ill from exercising in the heat?	Y	N
9. Do you cough, wheeze, or have trouble breathing during or or after activity?	Y	N
Do you have asthma?	Y	N
Do you have seasonal allergies that require medical treatment?	Y	N
10. 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)?	Y	N
11. Have you had any problems with your eyes or vision?	Y	N
Do you wear glasses, contacts, or protective eyewear?	Y	N
12. Have you ever had a sprain, strain, or swelling after injury?	Y	N
Have you broken or fractured any bone, or dislocated any joints?	Y	N
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	Y	N

If yes, circle appropriate location and explain below.

Head	Upper arm	Hand	Knee	Back	Elbow
Finger	Shin/calf	Chest	Forearm	Hip	Ankle
Shoulder	Wrist	Thigh	Foot		

13. Do you want to weigh more or less than you do now?	Y	N
Do you lose weight regularly to meet weight requirements for your sport?	Y	N
14. Do you feel stressed out?	Y	N

15. Record the dates of your most recent immunizations (shots) for

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

To the best or our knowledge, answers are complete and correct.

Signature _____ **Date** _____

Pre-Participation Physical Evaluation

(This page to be completed by physician/nurse practitioner/physician assistant)

PHYSICAL EXAMINATION DATE OF EXAM _____

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ % BODY FAT (optional) _____ PULSE _____ BP _____

VISION R 20/ _____ L 20/ _____ CORRECTED? Y _____ N _____ PUPILS: EQUAL / UNEQUAL (circle)

	NORMAL	ABNORMAL FINDING	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

____ Cleared

____ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

_____ Not Cleared for Sports: _____ Reason: _____

Recommendation: _____

_____

_____

Name of physician/nurse practitioner/physician assistant_____ Date: _____

(PRINT OR TYPE)

Address: _____ Phone: _____

Signature of physician/nurse practitioner/physician assistant _____