Parental Consent Form

__Prince George's County Public School "DON'T GET BENCHED" Sports Physical Initiative

Dear Parents/Guardians,

Elaine Ellis Center of Health (EECH) is providing **Sports Physicals at your child's school**. If you wish for your child to participate, ***please legibly complete the following information.*** Please also attach a copy of your picture identification card to further support your consent.

Child's Name: _____

Date of Birth: _____ Age: _____ Sex: ____ M ____ F Address:

_____ City: _____ State: _____ Zip Code: _____ Phone

Number: _____ Email Address: _____ Do we

have your permission to call you? Yes __No __ Text you? Yes __No __ Email you? Yes __ No __ What

school does your child attend? _____ Grade_____

Additional Information

Who is your child's Primary Care Physician? _____

Is your child on any medication(s)? Yes __ No __ Name of medication? _____

Does your child have allergies to any medication(s)? Yes __ No __ Reaction: _____

Has your child had any past medical problems? Yes __ No __ or Surgery? Yes __ No __

If yes, please explain:

_____

Does your child have a Dentist? Yes __ No __ If so, when was your child last seen? _____

Does your child participate in any sports? Yes __ No __ Name of Sport: _____

Insurance:

Health Insurance: _____ Policy Number_____

Policy Holder: _____ My child does not have health insurance _____

I am the legal parent/guardian of the above named child and I give my consent for EECH to give my child a sports physical at school.

Further, if applicable, I give permission for EECH to mail referrals and/or prescriptions to the address provided above.

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

updated February 2019

Estimados Padres/Guardianes,

Parental Consent Form

El centro de salud Ellaine Ellis (EECH) esta proveendo Cuidado rutinario/Examenes fisicos en la escuela de su hijo. Si usted desea que su hijo participe, llene la siguiente informacion y adjunte también una copia de su tarjeta de identificación con foto para respaldar el consentimiento.

Nombre de Nino(a): _____

Fecha de nacimiento: _____ Edad: _____ Sexo: ____ M ____ F

Direccion: _____ Ciudad: _____Estado: _____Codigo Postal: _____

Numero de telefono: _____Correo Electronico:_____

Tenemos permiso de llamarle? Si __No __ Mandar mensaje de texto? Si __No __ Mandar correo Electronico? Si __ No __

Que escuela atiende su hijo(a)? _____ Grado_____

Additional Information

Quien es el doctor primario de su hijo(a)? _____

Esta su hijo tomando medicamentos? Si __ No __ Nombre de medicamentos?

_____ Es su hijo alergico a algun medicamento(s)? Si __ No __ Reaccion:

_____ Ha tenido su hijo algun problema medico en el pasado? Si __ No __

Sirujias? Yes __ No __

Si ha tenido sirujias por favor explique:

_____

Su hijo tiene Dentista? Si __ No __ Cuando fue la ultima visita dental? _____

Participa su hijo(A) en deportes? Si __ No __ Nombre del deporte: _____

Seguro:

Seguro Medico: _____ Numero de Poliza:_____

Nombre en la poliza: _____ Mi hijo no tiene seguro

Soy el guardia legal de el paciente escrito arriba y doy consentimiento a EECH que haga un examen fisico en la escuela.

Además, si corresponde, doy permiso a EECH para que envíe referencias y / o recetas a la dirección

proporcionada anteriormente.

Nombre de padre/Guardian: _____
Firma de padre/Guardian: _____ Fecha: _____

updated November 2018

Prince George's County Public Schools

Parental Permission for Participation in Interscholastic Athletics

Please fill in the appropriate blanks and return this form to the head coach of the sport in which you wish your son/daughter to participate. Permission to participate is not granted unless this form is signed by the parent or legal guardian. Permission applies only to the sport specified. A new form *shall* be submitted if guardianship or insurance information changes.

My child, _____, has my permission to participate in the
First Name Last Name

following Prince George's County athletic program for the _____ school year.

School _____ Sport _____

_____ __/__/____ _____
Parents/Guardian Signatures (Date) Address

_____ _____ **Home**
Phone Work Phone

Request for Student Pre-Participation Physical Evaluation Form

It is extremely important that the school maintain a copy of your child's pre-participation evaluation form in the individual school record kept in the school health nurse's suite. Pre-participation forms are to be collected by the athletic director. The forms *shall* be kept in a secure file at all times.

Please sign and date if you agree to have your child's physical evaluation form on file.

_____ _____/_____/_____ **Parent or Guardian Signature (Date)**

Insurance Information

The school does not provide insurance coverage for athletes other than the group catastrophic policy for county football programs. All participants *shall* have their own insurance coverage in effect prior to participation to cover injuries that might arise.

My child has injury insurance coverage under policy #_____

through _____.
Insurance Company

_____ _____/_____/_____ **Parent or Guardian Signature (Date)**

In case of an emergency in which your child needs immediate medical treatment, we will send him/her to the nearest hospital and notify you immediately. The phone numbers you supply are of the utmost importance and should be updated when a change occurs. Please list your doctor's name and phone number so that he may be contacted if necessary:

Name of Doctor _____ Phone Number(s) _____

PGIN 7540-2205 A

■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y frme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____ Fecha del examen médico: _____ Deporte(s): _____ Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifca? (F, M u otro): _____

Mencione los padecimientos médicos pasados y actuales que haya tenido.

_____

_____

_____ ¿Alguna vez se le practicó una cirugía? Si la respuesta es afrmativa, haga una lista de todas sus cirugías previas.

_____

_____

_____

_____ Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume.

_____

_____

_____ ¿Sufre de algún tipo de alergia? Si la respuesta es afrmativa, haga una lista de todas sus alergias (por ejemplo, a algún medica mento, al polen, a los alimentos, a las picaduras de insectos).

_____

_____

_____

_____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma ≥3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fn de obtener un diagnóstico).

1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitente mente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene prob lemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electro cardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

11. ¿Alguno de los miembros de su familia o pari ente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente auto movilístico inexplicables)?		

12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la mio cardiopatía hipertrófca (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ven tricular polimórfca catecolaminérgica (CPVT)?		
13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfbrilador antes de los 35 años?		
14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articu lación o tendón que le hizo faltar a una práctica o juego?		
15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
16. ¿Tose, sibila o experimenta alguna difcultad para respirar durante o después de hacer ejercicio?		
17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?		

20. ¿Alguna vez sufrió un traumatismo craneoence fálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22. ¿Alguna vez se enfermó al realizar		

ejercicio cuando hacía calor?		
23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25. ¿Le preocupa su peso?		
26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28. ¿Alguna vez sufrió un desorden alimenticio?		
29. ¿Ha tenido al menos un periodo menstrual?		
30. ¿A los cuántos años tuvo su primer periodo menstrual?		

31. ¿Cuándo fue su periodo menstrual más reciente?	
32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?	

Proporcione una explicación aquí para las preguntas en las que contestó "Sí".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

__ Firma del padre o tutor: _____

Fecha: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____ Date of examination: _____ Sport(s): _____ Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions.

_____

_____

_____ Have you ever had surgery? If yes, list all past surgical procedures.

_____

_____

_____ Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

_____

_____ Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging

insects).

_____

_____

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.) Not at all Several days Over half the days Nearly every day

Feeling nervous, anxious, or on edge 0 1 2 3 Not being able to stop or control worrying 0 1 2 3 Little interest or pleasure in doing things 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3 (A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, futter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defbrillator before age 35?		

14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
16. Do you cough, wheeze, or have diffculty breathing during or after		

exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any prob lems with your eyes or vision?		

29. Have you ever had a menstrual period?		
30. How old were you when you had your frst menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

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

Signature of athlete:

_ Signature of parent or guardian:

Date:

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, e-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-enhancing 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 (Q4–Q13 of History Form).

Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insuffciency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fngers		
Hip and thigh		
Knee		

Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination fndings, or a combi nation of those.

Name of health care professional (print or type): _____ Date: _____ Address: _____

Phone: _____ Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classifcation (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysrefexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Diffculty controlling bowel		
Diffculty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifda		
Latex allergy		

Explain "Yes" answers here.

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

Signature of athlete:

Signature of parent or guardian:

Date:

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: Date of birth:

□ Medically eligible for all sports without restriction

□ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

_____

_____ □ Medically eligible for certain sports

_____

_____

_____

_____ □ Not medically eligible pending further evaluation

□ Not medically eligible for any sports

Recommendations:

_____

_____

_____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination fndings are on record in my offce 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____ Address: _____ Phone: _____ Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies:

_____

_____

_____

_____

_____

_____ Medications:

_____

_

_____

_____

_____

_____ Other information:

_____

_____

Emergency contacts:

PRE-PARTICIPATION COVID-19
Supplemental Questions for Student's Physical

This form should be completed by the student's physician at the time of a physical. **Student History**

1. Has your child or adolescent been diagnosed with COVID-19?

   Yes No

2. Was your child or adolescent hospitalized as a result for complications of COVID-19?

   Yes No

3. Has your Child been diagnosed with Multi-inflammatory Syndrome in Children?

   Yes No

4. Has your child or adolescent had direct known exposure to someone diagnosed with COVID-19?

   Yes No

Please address any "yes" answers to the above questions here:

COVID-19 Awareness
Parent/Student-Athlete Participation Acknowledgement Statements

I _____, the parent/guardian of _____, acknowledge that I have received information on all of the following:

- What you should know about COVID-19 to protect yourself and others • Share facts about COVID-19
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- COVID-19 Frequently Asked Questions from the Maryland State Health Department. https://coronavirus.maryland.gov/#FAQ

I _____, the parent/guardian of _____, will follow the requirements for in-person attendance at any extracurricular athletic and activity event.

- I will not send my child to extracurricular athletic and activities if they are exhibiting any signs/symptoms of COVID 19 or have been exposed to someone with COVID 19 (or presumed to have COVID 19) in the past 14 days.
- I will review symptoms with my child and monitor my child's symptoms every day that my child attends in-person activities/events.
- If my child becomes ill during any in-person activity/event, I will ensure they are picked up promptly. I will follow-up with an authorized health care provider/health department and comply with recommended quarantine or isolation as directed. If my child is ill, I understand that a release to return to in-person activity from an authorized health care provider will be required.

Signs and Symptoms of COVID-19:

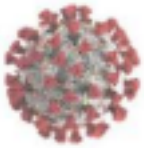
- Fever (100.4°F or greater) or chills • Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell • Sore throat
- Congestion or runny nose • Nausea or vomiting • Diarrhea

Students must be free of fever without the use of fever reducing medications.

Parent/Guardian_____ **Parent/Guardian**_____
Print Name Signature and Date

Student Athlete_____ **Student Athlete**_____ **Print Name Signature and Date**

What you should know about COVID-19 to protect yourself and others



Know about COVID-19

- Coronavirus (COVID-19) is an illness caused by a virus that can spread from person to person.
- The virus that causes COVID-19 is a new coronavirus that has spread throughout the world.
- COVID-19 symptoms can range from mild (or no symptoms) to severe illness.

Know how COVID-19 is spread

- You can become infected by coming into close contact (about 6 feet or two arm lengths) with a person who has COVID-19. COVID-19 is primarily spread from person to person.
- You can become infected from respiratory droplets when an infected person coughs, sneezes, or talks.
- You may also be able to get it by touching a surface or object that has the virus on it, and then by touching your mouth, nose, or eyes.

Protect yourself and others from COVID-19

- There is currently no vaccine to protect against COVID-19. The best way to protect yourself is to avoid being exposed to the virus that causes COVID-19.
- Stay home as much as possible and avoid close contact with others.
- Wear a cloth face covering that covers your nose and mouth in public settings.
- Clean and disinfect frequently touched surfaces.
- Wash your hands often with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer that contains at least 60% alcohol.

Practice social distancing

- Buy groceries and medicine, go to the doctor, and complete banking activities online when possible.
- If you must go in person, stay at least 6 feet away from others and disinfect items you must touch.
- Get deliveries and takeout, and limit in-person contact as much as possible.

Prevent the spread of COVID-19 if you are sick

- Stay home if you are sick, except to get medical care.
- Avoid public transportation, ride-sharing, or taxis.
- Separate yourself from other people and pets in your home.
- There is no specific treatment for COVID-19, but you can seek medical care to help relieve your symptoms.
- If you need medical attention, call ahead.

Know your risk for severe illness

- Everyone is at risk of getting COVID-19.
- Older adults and people of any age who have serious underlying medical conditions may be at higher risk for more severe illness.

CDC

cdc.gov/coronavirus