



## **Nebraska School Activities Association School Sports Qualifying Screening Evaluation**

**Please Complete in Ink**

### *INSTRUCTIONS FOR COMPLETING THE PRE-PARTICIPATION FORM*

#### **REASONS FOR RECOMMENDED CHANGES IN PRE-PARTICIPATION PHYSICAL FORMS**

Due to privacy and HIPAA issues, the NSAA's Sports Medicine Advisory Committee has recommended that schools utilize a different form and different procedures than have previously been used for activities pre-participation physical examinations. Medical professionals on the NSAA Sports Medicine Advisory Committee expressed concerns that collection of and access to confidential student medical information by schools would likely constitute an infringement of privacy and HIPAA guidelines.

In the past, the two-part NSAA pre-participation physical form included (1) a page of student medical history, and (2) a page with the actual examination report. Once the physical examination was completed, both the medical history and examination report were filed with the student's high school—a practice that has been challenged as infringing on privacy and HIPAA regulations.

The attached form is a product of and used with the approval of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

This proposed three-part form includes (1) a History Form; (2) the actual Physical Examination Form; and (3) the Clearance Form. To meet privacy and HIPAA requirements, it is anticipated that the examining physician would retain on file the History Form and the Physical Examination Form, with only the Clearance Form being returned to the student to be placed on file in the school office.

#### **SCHOOL ENTRY PHYSICAL EXAMINATIONS**

This physical examination form and procedures is intended for pre-participation athletic physicals. In the past, some schools have utilized the NSAA physical form for school-entry physicals. This form could be used for that purpose, as well, but it is important to note that there may be important components of the school-entry physical examination requirements that are not included on this form (e.g., vision examination).

#### **SIGNATURE(S)**

For the form to be valid, it must be signed by a physician or medical person within the scope of his/her training and within the limits defined by state statutes as to services which can be legally performed by the field of practice to which the individual belongs.

#### **PARENTAL CONSENT FORM**

The Parental Consent Form is a form based on current language making sure parents and athletes understand completely there are risks with any athletic activity. This form is very "generic" and can be easily modified to fit the individual school. Since some schools may want to be very specific in their forms, this form may be modified. It is currently designed to refer to a school's specific sets of policies, rules and regulations for athletic participation. The Parental Consent Form should be placed on file for every student who participates in NSAA activities, athletic and non-athletic.

# Preparticipation Physical Evaluation

**HISTORY  
FORM**

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

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/ahin	Ankle	Foot/toes

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

- FEMALES ONLY**
- |  |                          |                          |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? | _____                    |                          |
| 49. How many periods have you had in the last year?            | _____                    |                          |

**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 \_\_\_\_\_

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# 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 \_\_\_\_\_

### Follow-Up Questions on More Sensitive Issues

	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days, have you had at least 1 drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary†			
Skin			
<b>MUSCULOSKELETAL</b>			
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:

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

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation)  Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation)  Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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To be completed for  
Students participating in any  
NSAA activities.

**Student and Parent Consent Form**



School Year: 20 24 -20 25  
Member School: Bayard Public Schools  
Name of Student: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic and activity participation; (b) participation in any activity may involve injury or illness of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) the severity of an illness, including contagious diseases such as the COVID-19 virus, and bacterial infections may be so severe as to result in disability and death; and, (e) even with the best supervision, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA Bylaws and rules interpretations for participation in NSAA sponsored athletic and/or activities, and the athletic and activities rules of the NSAA member school for which the Student is participating; and,
- (4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the Student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and athletics, weight and height as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.
- (5) Consent and agree to authorize licensed sports injury personnel to evaluate and treat any injury or illness that occurs during the Student's participation in NSAA activities. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries. This would also include transportation of the Student to a medical facility if necessary. Such licensed sports injury personnel are independent providers and are not employed by the NSAA.
- (6) Acknowledge that Parents are obligated to pay for professional medical and/or related services; the NSAA shall not be liable for payment of such services. We give permission to any and all of the Student's health care providers and the NSAA and its employees, staff, agents, and consultants to release and discuss all records and information about the Student including otherwise confidential medical information and records. We understand that this release has been requested and may be used for the purpose of determining eligibility pertaining to activities participation, fitness, injury, injury status, or emergency.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities.

\_\_\_\_\_  
Name of Student [Print Name] Student Signature Date

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities. Having read the warning in paragraph (2) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for \_\_\_\_\_ [insert Student name] to practice and compete for the above named high school in activities approved by the NSAA, **except those crossed out below:**

Baseball	Basketball	Bowling	Cross Country	Debate	Football	Golf
Journalism	Music	Play Production	Soccer	Softball	Speech	Swim/Dive
Tennis	Track & Field	Unified Bowling	Unified Track & Field	Volleyball	Wrestling	

<b>Parent(s)/Guardian Printed Name(s)*</b>	<b>Parent/Guardian Signature</b>	<b>Date of Signature</b>

**\*Both Mother and Father must sign, unless parents are divorced, the custodial parent must sign, or if the Student is not living with parents, the Student's legal guardian.**