ASAA PARENT AND STUDENT VERIFICATION OF RECEIPT OF INFORMATION CONCERNING CONCUSSIONS

In accordance with AS 14.30.142, the School District requires that each athlete, and each minor athlete's parent/guardian, receive written information on the nature and risks of concussions each year. Students may not participate in school athletic activities unless the student and parent/guardian of a student who is under 18 years of age have signed a current verification that they have received the information provided by the District. Parents will be provided with a pamphlet provided by the Alaska School Activities Association entitled "A Parent's Guide to Concussions in Sports." Students will be provided with a fact sheet produced by the U.S. Dept. of Health and Human Services Centers for Disease Control and Prevention entitled "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes." Students who are 18 years of age or older will also be provided with the Parent's Guide.

Parents and Students should review this information, discuss it at home, and direct any questions to the student's coach, school principal or athletic activities director.

Student Acknowledgement (required for all athletes)

I acknowledge that I have received a copy of "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes" and understand its contents.

Student Signature | **Print Name**

Date

_____/_____/_____

Parent/Guardian/Eligible Student Acknowledgement
(Parent signature required for all students under 18 years of age; student signature required for students age 18 or older)

I acknowledge that I have received a copy of "A Parent's Guide to Concussions in Sports" and understand its contents.

Parent/Guardian/Eligible Student Signature | **Print Name**

Date

_____/_____/_____

ALASKA SCHOOL ACTIVITIES ASSOCIATION, INC.
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Play for Keeps
ALASKA SCHOOL ACTIVITIES ASSOCIATION

Student, Parent/Guardian Acknowledgement Form

Please read the following statements, sign below and return to your school's office

- I have participated in ASAA's "Play for Keeps" orientation and have watched the DVD presentation.
- I understand the terms of the Tobacco, Alcohol and Controlled Substances Policy as explained during the presentation, including the penalties for violations.
- I further understand that it is solely the school's responsibility to determine if a violation has occurred and that the school's decision may not be appealed to ASAA.
- I further understand that schools are required to report each violation to ASAA and to maintain strict confidentiality as specified in the policy. More specific wording of the confidentiality statement is found in the policy which is available from the school or at www.asaa.org.
- I further understand that students must participate in the orientation and sign this form each season prior to competition.
- I further understand that a student's parent/guardian must participate in the orientation and sign this form at least annually for the student to gain eligibility.
- I further understand that a copy of this signed form must be returned to the school before the student is permitted to participate in interscholastic activities.
- I further understand that schools shall keep a copy of the signed forms on file.
- After participating in the "Play for Keeps" orientation and having the opportunity to review and understand ASAA' s Tobacco, Alcohol and Controlled Substances Policy, the violations, penalties and reporting requirements, I agree (both student and parent/legal guardian) to be bound by the terms of the policy.

Printed Name of Student	**Student Signature**	**Date**
		_____/_____/_____

Printed Name of Parent/Guardian	**Parent/Guardian Signature**	**Date**
		_____/_____/_____

Sport or Activity	**School**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION RELATING TO STUDENT HEALTH REVIEW/EXAM

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

_____/_____/_____

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

_____/_____/_____

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

_____/_____/_____

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam** (_____/_____/_____)

Are your immunizations up to date ☐ Yes ☐ No | **Last tetanus shot** (_____/_____/____) | **Last measles shot** (_____/_____/___) | **Last TB skin test** (_____/_____/___)

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
2.	Have you ever had surgery?	☐	☐
3.	Are you presently taking any medications or pills?	☐	☐
4.	Have you ever passed out during or after exercise?	☐	☐
5.	Have you ever been dizzy during or after exercise?	☐	☐
6.	Have you ever had chest pain during or after exercise?	☐	☐
7.	Do you tire more quickly than your friends during exercise?	☐	☐
8.	Have you ever had high blood pressure?	☐	☐
9.	Have you ever been told that you have a heart murmur?	☐	☐
10.	Have you ever had racing of your heart or skipped beats?	☐	☐
11.	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
12.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
13.	Have you ever had a head injury?	☐	☐
14.	Have you ever had a concussion? If yes, how many_____	☐	☐
15.	Have you ever been knocked out or unconscious?	☐	☐
16.	Do you suffer from migraines?	☐	☐
17.	Have you ever had a seizure?	☐	☐
18.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
19.	Have you ever had heat or muscle cramps?	☐	☐
20.	Have you ever been dizzy or passed out in the heat?	☐	☐
21.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
22.	Do you use any special equipment *(pads, braces, neck rolls, mouth guards, eye guards, etc.)*?	☐	☐
23.	Have you ever had problems with your eyes or vision?	☐	☐
24.	Do you wear glasses or contacts or protective eye wear?	☐	☐
25.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand	☐	☐
26.	Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*?	☐	☐
27.	Have you had any medical problem or injury since your last evaluation?	☐	☐
28.	Are you Diabetic?	☐	☐
29.	Are you Asthmatic?	☐	☐
30.	Do you have any allergies *(medicine, bees or other stinging insects)*??	☐	☐

List all allergies: _____

31. When was your first menstrual period? _____

When was your last menstrual period? _____

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

32. Explain all "yes" answers: _____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant or advanced nurse practitioner

This form to be sent to the school (do not send to ASAA)

Student Last Name	Student First Name	MI	Date of birth	Grade
			_____/_____/_____	

Height	Weight	Blood Pressure	Pulse

Vision — Right Eye	Vision — Left Eye	Vision Corrected?	Pupils
20/	20/	☐ Yes ☐ No	

	NORMAL	ABNORMAL FINDINGS	INITIALS
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:
- ☐ Cleared
- ☐ Cleared after completed evaluation/rehabilitations for (Specific Sports): _____
- ☐ Not cleared for: ☐ Collision ☐ Contact ☐ Noncontact ☐ Strenuous ☐ Moderately Strenuous ☐ Nonstrenuous

Due to: _____

_____

Name of M.D., P.A. or ANP (circle which)	Signature	Date
		_____/_____/_____

Address	Phone

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