**PHYSICAL, CONCUSSION, RESIDENCY, AND PERMISSION FORM**

**LEWISBURG MIDDLE/HIGH SCHOOL ATHLETICS**

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First Middle

DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Gender: Male\_\_\_\_\_\_\_\_\_\_ / Female\_\_\_\_\_\_\_\_\_\_

Street Address (No PO Boxes Please): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier and Policy Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Are you a resident of the Lewisburg School Zone? Yes\_\_\_\_\_\_\_\_\_\_ /No\_\_\_\_\_\_\_\_\_\_**

**If no, list reason for your transfer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If no, in what year and what grade did you enroll in Lewisburg \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***MHSAA Concussion Policy:***

* *An athlete who reports or displays any symptoms or signs of a concussion in a practice or game setting should be removed immediately from the practice or game. The athlete should not be allowed to return to the practice or game for the remainder of the day regardless of whether the athlete appears or states that he/she is normal.*
* *The athlete should be evaluated by a licensed, qualified medical professional working within their scope of practice as soon as can be practically arranged.*
* *If an athlete has sustained a concussion, the athlete should be referred to a licensed physician preferably one with experience in managing sports concussion injuries.*
* *The athlete who has been diagnosed with a concussion should be returned to play only after full recovery and clearance by a physician. Recovery from a concussion, regardless of loss on consciousness, usually take 7-14 days after resolution of all symptoms.*
* *Return to play after a concussion should be gradual and follow a progressive return to competition. An athlete should not return to a competitive game before demonstrating that he/she has no symptoms in a full supervised practice.*
* *Athletes should not continue to practice or return to play while still having symptoms of a concussion. Sustaining an impact to the head while recovering from a concussion may cause Second Impact Syndrome, a catastrophic neurological brain injury.*

I give my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, permission to participate in athletics for Lewisburg Middle/High School, and to receive a pre-participation physical for athletic activities. I have also reviewed the MHSAA Concussion Policy. I am aware that a release by a medical doctor is required before my child may return to active competition after a concussion diagnosis.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information below to be filled out by physician only

Height

## **General Medical Exam:**

Weight

Blood Pressure

**Pulse**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Norm Abnl** | Norm Abnl |  | Norm Abnl |
| ENT | Lungs |  | Hernia (if Needed) |  |
| Heart  Skin | Abdomen |  | Marfan Stigmata |  |

Comments

**Flexibility Exam:**

LEFT RIGHT

LEFT RIGHT

LEFT RIGHT

Neck

Hips

Hams

Back Ext / Flex

Shoulder

Ouads

##### Heelcords

Comments

## **Orthopaedical Exam:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Spine / Neck | Norm Abnl | II. | Upper Extremity | Norm Abnl | III. | Lower Extremity | Norm Abnl |
|  | Cervical |  |  | Shoulder |  |  | Hip |  |
|  | Thoracic |  |  | Elbow |  |  | Knee |  |
|  | Lumbar |  |  | Wrist |  |  | Anlde |  |
|  |  |  |  | Hand / Fingers |  |  | Feet |  |

Other Comments

# Optional Exams:

DENTAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

VISION L R

Comments :

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### [ ] From this limited screening I see no reason why this student cannot participate in athletics

##### [ ] Student needs further evaluation as described

Typed or Printed Name of Physician

, M.D.

SIGNATURE OF PHYSICIAN