Commerce Athletic Training

To: Commerce ISD Returning Student-Athletes and Parents

From: Amanda Herron MS, ATC, LAT
Head Athletic Trainer

Subject: Student-Athlete Pre-Season Forms

Attached are the instructions to complete the medical paperwork for participation in any athletic activities for the 2018-2019 athletic year. **ALL STUDENT-ATHLETES must have a physical prior to the start of your season to compete each year**. Please keep in mind that this form is confidential and is for your benefit. Forms will be completed on ATS Athletic Trainer Software.

Physical Exam: Needs to be completed by a Medical Doctor. The physical form is attached. Complete Authorization to treat form. Physicals will be provided during the school day this spring free of charge. All forms must be completed prior to receiving a physical exam.

Returning Users Instructions:

1. GO TO: commerceisd2.atsusers.com to enter the Athlete Portal
2. Enter your **Athlete ID** and **Password**. (Database: atscommerceisd)
    a. If you forgot your ID or Password – ASK!!
3. Click on Athlete Information
4. Update Demographic, Insurance and Contact information.
5. **"Forms" Tab:** Complete all 6 Forms. ("Form Name" dropdown box > select a form > click "new" > read, complete and sign each form > click "Save".)
    a. Medical History
    b. MD Release, Handbook, Insurance, Med Admin
    c. UIL Sudden Cardiac Arrest Awareness Form
    d. Concussion Acknowledgement Form
    e. Eligibility Acknowledgement Form
    f. Anabolic Steroid Use and Random Drug Testing
6. **Physical Exam:** Get a physical and RETURN to CHS.

Return the completed PHYSICAL to:
Amanda Herron at CHS.
Head Athletic Trainer
Office: 903.886.3756
Fax: 903.886.6209
Email: amanda.parsley@commerceisd.org

Commerce ISD Insurance Statement:
Commerce ISD provides student accident insurance coverage free of charge for students who participate in U.I.L. activities. This coverage acts as a supplement (secondary) to any coverage that you may have. The individual's insurance coverage is primary. Once your primary insurance has paid, then the remaining expenses, up to the maximum benefits allowed, will be paid by the supplemental policy. If the individual does not have primary insurance coverage, the school insurance will only pay the maximum benefits allowed. Claims for the Commerce ISD insurance must be filed within 90 days and treatment must commence within 90 days from the date of injury. **There is no guarantee that all medical expenses will be covered. The Parent/Guardian is responsible for any remaining expenses left uncovered or unpaid.** Only athletic related accidents occurring while an athlete is representing the Commerce ISD in a formal athletic-sponsored activity will be covered (i.e. practice or game) unless approved by the Commerce ISD Athletic Administration.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition that would make it hazardous to participate in an athletic event.

Student's Name: (print) _____Sex _____ Age_____ Date of Birth_____

Address _____ Student's Phone: _____

Grade _____ School _____

Personal Physician: _____ Phone: _____

In case of emergency, contact:
Name: _____ Relationship_____ Phone (C): _____ (Alternate)_____

Explain **"Yes"** answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had your heart race or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Had any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc) Marfan's Syndrome, or abnormal heart rhythm?	☐	☐
	Have you ever had a severe viral infection (ie. Myocarditis, or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If, yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain in "Yes" box)		
	Do you have frequent severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Have you ever had a seizure?	☐	☐
6.	Are you missing any paired organs?	☐	☐
7.	Are you under a doctor's care?	☐	☐
8.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
9.	Do you have any allergies (ie. To pollen, medicine, food, or insect stings)?	☐	☐
10.	Have you ever been dizzy during or after exercise?	☐	☐
11.	Do you have any current skin problems (ie. Itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
12.	Have you ever become ill from exercising in the heat?	☐	☐
13.	Have you had any problems with your eyes or vision?	☐	☐
14.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have any seasonal allergies that require medical treatment?	☐	☐
15.	Do you use any special protective for corrective equipment or devices that aren't usually used for sports for position (ie. Knee brace, neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
16.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check the appropriate box and explained below:		
	☐ Head ☐ Elbow ☐ Hip		
	☐ Neck ☐ Forearm ☐ Thigh		
	☐ Back ☐ Wrist ☐ Knee		
	☐ Chest ☐ Hand ☐ Shin/Calf		
	☐ Shoulder ☐ Finger ☐ Ankle		
	☐ Upper Arm ☐ Foot ☐ Toe		
17.	Do you want to weigh more or less than you do?	☐	☐
18.	Do you feel stressed out?	☐	☐
19.	Have you ever been tested for sickle cell disease or trait?	☐	☐
20.	Have you ever been diagnosed with or treated for sickle cell trait or disease?	☐	☐
	Females Only		
21.	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? _____		

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question 3 above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, nurse practitioner

** Explain "YES" answers in the box below (attach another sheet if necessary):

_____
_____
_____
_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither is the UIL nor the school assumes any responsibility.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that might limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL. I acknowledge and agree that all information on UIL required online forms is accurate and correct, including all electronic signatures. As guardian, I take full responsibility for reading and completing UIL forms with my child. The above student may receive a provided physical examination during school hours by a licensed provider unaccompanied by parent or guardian.

Student Signature: _____Parent/Guardian Signature:_____ Date: _____

Any yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical exam. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, game or match. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:
This medical history form was reviewed by: Printed Name: _____ Date_____ Signature_____

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Student's Name_____ Gender____ Age_____ Date of Birth_____

Height_____ Weight_____ Pulse _____ Blood Pressure _____/_____ (____/____ ,____/____)

Vision: R 20/_____ L 20/_____ Corrected: ☐YES ☐NO Pupils: ☐ EQUAL ☐ UNEQUAL

As a requirement of Commerce ISD, this PHYSICAL EXAM FORM **must** be completed prior to athletic participation each year (7-12th grades).

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIAL***
Appearance			
Eyes/Ears/Nose Throat			
Lymph Nodes			
Heart- Auscultation of the heart in the supine position			
Heart- Auscultation of the heart in the standing position			
Heart- Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Sickle Cell Trait Testing*			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/ rehabilitation for: _____

_____

☐ Not cleared for: _____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by the State of Physician Assistant Examiners, a Advanced Practice Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination form signed by any other healthcare practitioners will not be accepted.

Name (Print): _____ Exam Date: _____

Address: _____

Phone Number: _____ Signature: _____

Must be completed before a student participates in any practice, before, during or after school (both in-season and out-of-season) or games/matches. All UIL forms must be completed online at commerceisd2.atsusers.com

Student Name: _____ DOB: _____

Commerce ISD – Athletic Training
Authorization to Consent to Treatment of Minor & Medical Information Release

I, _____ (**parent/guardian name**), am the parent/guardian of

_____ (**name of minor**), a minor child, and have the power to consent to medical treatment for him/her. I authorize and appoint **Commerce ISD Athletic Trainer, Nurse, and/or Employed Coach** as my agent to consent to medical treatment of the minor when I cannot be contacted to so consent, such medical treatment to include, without limitation, X-ray examination; anesthetic treatment; medical, dental, or surgical examination or treatment; and general hospital care. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I authorize the release of information including the diagnosis, X-ray results, MRI results, restrictions, prescribed rehabilitation; examination rendered for my child. This information may be released to **Commerce ISD Athletic Trainer** as pertains to injury and illness affecting athletic participation**.**

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

_____ _____
Parent/guardian Signature **Date**

_____ _____
Parent/guardian Name Printed **Phone Number**

_____ _____
Additional Parent/guardian Name Printed **Phone Number**

Health Insurance Information

Policy Holder Name: _____ **DOB**: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number for Medical Professionals: _____

Group Number: _____ Plan/Network ID#: _____

Member ID #: _____