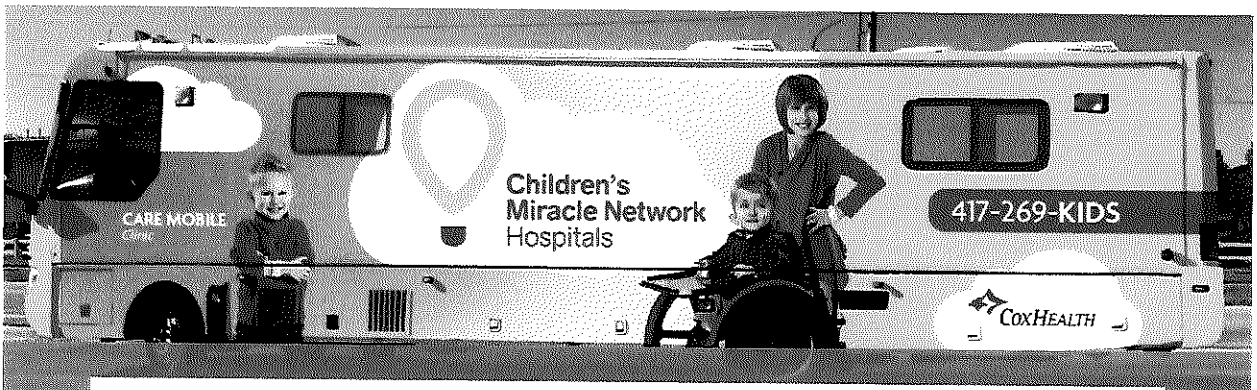

NEED A SPORTS PHYSICAL? NO SWEAT.

Sports Physicals will be provided by the Cox CARE Mobile at Marionville High School on Friday, June 28, 2019/9:00 AM- 3:30 PM for your convenience.

If you have Medicaid coverage, no insurance, or qualify for free or reduced lunches, *THE PHYSICAL IS FREE OF CHARGE*. Otherwise, the physical will be $10.

There are 3 ways to make your payment:

Option 1:

1. Call (417) 269-4353 and indicate you are pre-paying for a sports physical to be performed on the CARE Mobile
2. Provide the operator with your Visa, MasterCard or Discover information

Option 2:

1. Mail your check or money order payable to **CoxHealth CARE Mobile**
2. Please include student name, date of birth, and school on your check
3. Mail to: **CoxHealth**
   3355 S. National Ave.
   Suite 400
   Springfield, MO 65807

Option 3:

1. Go online to www.directconnectmenow.com
2. Click "yes" you are located in the state of Missouri
3. Enter **CMsport** as your plan code
4. Select **Pre-Pay CAREMobile**
5. Fill out the fields with your child's information
6. You will be prompted to pay $10 with your credit or debit card information
7. Print or screen shot your receipt

PLEASE PROVIDE PAYMENTS BY THURSDAY, JUNE 27, 2019
NO CASH WILL BE ACCEPTED ON THE COX CARE MOBILE BUS

CONSNT

CoxHealth
Regional Services
C.A.R.E. MOBILE REGISTRATION

Name: _____
Age: _____ DOB: ___/___/_____
SSN or ID: _____
(or Patient Sticker Here)

Child's Legal Name: _____ SSN#: _____ Birth Date : ___/___/_____
Sex: ☐ Male ☐ Female Address: _____ City: _____ State: _____ Zip: _____
School: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

FINANCIAL OBLIGATION*

PRIMARY INS: _____ **POLICY HOLDER NAME:** _____
Policy Holder's Employer: _____ Policy Holder SSN#: _____
Group #: _____ Policy/ID #: _____ Policy Holder DOB: ___/___/_____
Patient's Relationship to Policy Holder: ☐ Child ☐ Other (explain) _____

SECONDARY INS: _____ **POLICY HOLDER NAME:** _____
Policy Holder's Employer: _____ Policy Holder SSN#: _____
Group #: _____ Policy/ID #: _____ Policy Holder DOB: ___/___/_____
Patient's Relationship to Policy Holder: ☐ Child ☐ Other (explain) _____

☐ **NO INSURANCE** (SELF PAY) **STUDENT QUALIFIES FOR FREE OR REDUCED LUNCH?** ☐ **Yes** ☐ **No**

** The mission of the C.A.R.E. Mobile program is to provide access to health care for children in the Ozarks who have no insurance, do not have a primary care physician or whose parents cannot afford to pay for necessary services. However, no child will be turned away.*

PARENT OR GUARDIAN and EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Phone: _____ Relationship: _____
RELATIONSHIP: ☐ Father ☐ Mother ☐ Guardian
Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: ___/___/_____
Address: _____ City/State/Zip: _____ Home Phone: _____
Employer: _____ Work Phone: _____ Mobile Phone: _____
Preferred method of contact? ☐ Email ☐ Home Phone ☐ Letter ☐ Mobile Phone ☐ Work Phone

RELATIONSHIP: ☐ Father ☐ Mother ☐ Guardian
Name: (First, MI, Last) _____ SSN#: _____ Date of Birth: ___/___/_____
Address: _____ City/State/Zip: _____ Home Phone: _____
Employer: _____ Work Phone: _____ Mobile Phone: _____
Preferred method of contact? ☐ Email ☐ Home Phone ☐ Letter ☐ Mobile Phone ☐ Work Phone

FAMILY HISTORY

Ethnicity: ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Patient's biological family has a history of:

☐ Stroke	☐ Heart disease or heart attack	☐ Diabetes/sugar disease	☐ High blood pressure
☐ High cholesterol	☐ Diabetes/sugar disease	☐ Asthma	☐ Hearing loss at young age
☐ Vision loss at young age	☐ Alzheimer's disease/dementia	☐ Developmental delay/retardation	☐ Miscarriage/stillbirth
☐ Breast cancer	☐ Ovarian cancer	☐ Endometrial (uterine) cancer	☐ Colon cancer
☐ Birth Defects	☐ Genetic conditions: _____		

☐ Other Cancer(s): _____
☐ Genetic Conditions: _____
☐ Mental Health: _____
☐ Other Health Concerns: _____

Identify family members with each condition checked:

Relationship	Condition	Age of Onset	Current Age	Age and Cause of Death
Example: Grandmother on Father's Side	*High Blood Pressure*	*61*		*87, Stroke*

CONTINUED ON BACK

AUTHOR

CoxHealth
Regional Services
C.A.R.E. MOBILE AUTHORIZATION

Name: _____
Age: _____ DOB: ___/___/_____
SSN or ID: _____
(or Patient Sticker Here)

Child's Legal Name: _____ SSN#: _____ Birth Date : _____/_____/_____

Sex: ☐ Male ☐ Female Address: _____ City: _____ State: _____ Zip: _____

School: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

This Authorization, Financial Obligation ,Consent and Permission to Share form applies to the CoxHealth C.A.R.E. Mobile (hereinafter referred to as "CoxHealth").

Authorization to Release Information. The Notice of Privacy Practices sets forth rights regarding my child's personal health information and the manner in which it may be used or disclosed. This includes the sharing and/or receiving of prescription information with a prescription database utilized in electronically prescribing medications for my child's treatment, including the review and access to prescriptions prescribed to my child outside of the CoxHealth system. I understand that I have the following rights, among others, regarding my child's information: to receive the Notice of Privacy Practices prior to signing this form; to object to the use of my child's personal health information in any facility directory; and to revoke this form in writing, except to the extent that CoxHealth has already taken action in reliance on this form. I authorize the review, copying, release and disclosure of any and all information in my child's medical or accounting record(s), including information regarding the diagnosis or treatment of HIV, AIDS, mental illness or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment, continuity of care or other matters related to the treatment or services rendered to me by CoxHealth.

Assignment of Benefits. I assign to CoxHealth the benefits otherwise payable to me for any treatment from my insurance carrier or company, managed care plan, health maintenance organization, self-insured health plan, Medicaid or Medicare and its intermediaries and carriers.

Medicaid Beneficiaries. I authorize CoxHealth to obtain information from Missouri HealthNet or other government agencies regarding my entitlement to benefits and my health insurance claim numbers.

Financial Obligation. I understand that I am financially responsible for payment of all amounts due for services provided by CoxHealth regardless of whether I have insurance coverage or whether other parties may also be responsible for paying for my child's care. I will not be responsible to pay for such services rendered if my financial obligation is waived by contractual agreement or prohibited by applicable state or federal laws or regulations. I understand that, as a courtesy to me, CoxHealth will submit claims for third-party coverage to my disclosed insurance carriers and that CoxHealth is authorized to complete any forms which are needed in order to obtain payment from said third-party payers. For all past due accounts, I agree to pay interest at the legal rate if the amount for which I am responsible is not paid within thirty (30) days of receipt of the bill. As part of the collections process, I authorize CoxHealth and any of its agents attempting to collect an unpaid account balance to contact me at any telephone number or address I have provided to CoxHealth using any manner, including the use of an auto-dialing device, at any time until my debts are paid in full. I understand that the cost of collections on past due accounts, including reasonable attorney's fees and court costs, will be included as part of my financial obligation. This agreement shall be governed by Missouri law. I hereby agree venue shall be appropriate in Greene County, Missouri. I also understand, pursuant to the Missouri hospital lien statutes, that if my injuries were caused by the negligence or wrongful act of another, CoxHealth may have a lien on any and all claims or rights of action I may have against the person causing my injuries and CoxHealth may have the right to enforce the lien for payment of services rendered rather than seek payment from any third-party payer.

Consent for Treatment. I agree, request and authorize the school listed above to facilitate treatment and health care for my child that is to be provided by the CoxHealth C.A.R.E. Mobile program, including but not limited to: primary care services, immunizations, vision services, sports pre-participation physicals, and the treatment of common illnesses. I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for any the vaccine(s) my child will receive from CoxHealth. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to my child. I am authorized pursuant to Section 431.058 RSMo to make this request. I realize that among those who attend to patients at CoxHealth are medical, nursing and other healthcare personnel in training who may be present and participating in my child's care as part of their education. I also understand that CoxHealth utilizes the services of Non-Physician Practitioners, that my child may be evaluated and treated by one of these Non-Physician Practitioners and that I have the right to see that provider's collaborating physician. I authorize the taking of photographs, videos or other images of parts of my child's body for use in medical evaluation, education and security purposes. I am aware that the practice of medicine is not an exact science and I understand that no promise, guarantee or warranty has been made regarding the results of the examination or treatment my child receives.

Permission to Share Information. I understand that protected health information (PHI) may include records relating to psychiatric or psychological care; communicable diseases; HIV/AIDS diagnosis or treatment; alcohol or drug abuse treatment; sexually transmitted diseases; and other sensitive information.

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

___ I authorize the release of financial and PHI from the entire CoxHealth system and its Affiliated Covered Entities.

___ I DO NOT authorize the release of financial and PHI from the following entity(s): _____

- In the case of an emergency situation CoxHealth may determine that a limited disclosure may be in my child's best interests and I realize CoxHealth may share limited PHI or other information with those who may be involved in my child's care.
- I relize this form does NOT authorize the person(s) below to make health care decisions for my child or to view or receive copies of my child's medical records.

			Type of Information			
Name:	Phone Number:	Relationship to patient:	All	Scheduling / Appointment	Medical	Insurance / Billing

This covers the following time frames. If NOT marked, all past present, and future encounters are the default.

___ All past, present, and future encounters/visits -OR- Other: _____

Time Limit and Right to Revoke. Except to the extent that action has already been taken in reliance on this authorization, I have the right to revoke this authorization at any time. Unless otherwise revoked, this authorization shall terminate one (1) year from the date signed.

Signature of Parent or Legal Guardian (If unable to sign, Representative name ansd Relationship) | Date | Signature of Witness | Date

PRE-PARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart for their records).

Date of Exam:				
Name:				Date of Birth:
Sex:	Age:	Grade:	School:	Sport(s):

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies: Yes ☐ No ☐ If yes, please identify specific allergy below:

☐ Medicines: ☐ Pollens: ☐ Food: ☐ Stinging Insects:

Explain "Yes" answers below. Circle questions you do not know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High blood pressure ☐ A heart murmur ☐High cholesterol ☐ A heart infection ☐Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males) or spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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(s) or Guardian:**	**Date:**

PRE-PARTICIPATION PHYSICAL EVALUATION
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, 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 supplements?
   - 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 (Questions 5-14).

EXAMINATION

Height:	Weight:	☐ Male	☐ Female
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal pulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)**		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic***		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam; **Consider GU exam if in private setting. Having third party present is recommended.
***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction.

☐ Cleared for all sports without restriction **with recommendations for further evaluation or treatment for:**

☐ Not Cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports (please list):

Reason:

Recommendations:

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (type/print):	Date:
Address:	Phone:
Signature of Physician (MD/DO/ARNP/PA/Chiropractor):	

PRE-PARTICIPATION PHYSICAL EVALUATION
Missouri State High School Activity Association (MSHSAA) Eligibility and Authorization Statement

STUDENT AGREEMENT (Regarding Conditions for Participation)

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at www.mshsaa.org).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signature of Athlete:	**Date:**

PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)

Informed Consent: By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA- SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We authorize the release of necessary medical information to the physician, athletic trainer, and/or school personnel related to such treatment/care. We understand that the school may not provide transportation to all events, and permit / do not permit (CIRCLE ONE) my child to drive his/her vehicle in such a case.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

Name of Insurance Company:	Policy Number:
Signature of Parent(s) or Guardian:	Date:

PARENT AND STUDENT SIGNATURE (Concussion Materials)

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

Signature of Athlete:	Date:
Signature of Parent(s) or Guardian:	Date:

EMERGENCY CONTACT INFORMATION

Parent(s) or Guardian	Address	Phone Number
Name of Contact	Relationship to Athlete	Phone Number
Name of Contact	Relationship to Athlete	Phone Number