

Parents and Student-Athletes;

As we get ready for the next school year, this is a reminder that you need a physical on file at the school in order to participate in athletics during the 2019-20 school year. Every student-athlete in grades 7 through 12 must take a physical before they can participate in a sport at Elk Point-Jefferson.

The physicals that you take for the current school year (2019-20) may be commenced any time after April 1, 2019 and will be effective until August 1, 2020. *Please note that regardless of when you take your physical this year, it will not be valid after August 1, 2020.*

Any certified Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner can administer this physical and sign the forms.

You will need to make sure that you have the proper form that is authorized by Elk Point-Jefferson and the South Dakota High School Activities Association. The total packet includes:

- 1. Annual Parental Permit**
- 2. Interim Pre-Participation History Form**
- 3. Initial Pre-Participation History Form**
- 4. Release of Medical Information Form (HIPAA)**
- 5. Concussion Fact Sheet for Athletes**
- 6. Concussion Fact Sheet for Parents**
- 7. Physical Form and Instructions**
- 8. Parent and Student Consent Form / Medical Consent Form**

This packet is available on the EPJ website (www.epj.k12.sd.us) under the activities tab or you can pick one up at the high school office with Julie Koupal. All athletes in grades 7-12 are required to have a physical in order to participate in sports.

Thank you for taking care of this and if you have any questions feel free to contact Justin Clercx at Justin.Clercx@k12.sd.us. When you have everything filled out, please turn in your physical packet to Julie Koupal.

Have a great summer and we will see you all soon!

It is a great day to be a Husky!!

Sincerely,

Justin Clercx

Justin Clercx, 7-12 Activities Director

PREPARTICIPATION 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 this form in the chart.)

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 don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, 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 <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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/guardian _____ Date _____

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION

**PHYSICAL EXAMINATION
ITEMS TO BE EVALUATED**

Station 1 - Individual History

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

Station 2 - Blood Pressure

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75
12 years and older 140/85

Station 3 - Vision (Snellen)

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

Station 4 - Skin, Mouth, Eyes, Ears

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

Station 5 - Chest

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

Station 6 - Lymphatics, Abdomen, Genitalia

Cervical or axillary adenopathy, organomegaly, absence of testicles, and hernia (males only).

Station 7 - Orthopedic

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

Station 8 - Review

CLEARANCE

- Cleared for ALL (*collision, contact/endurance sports, and other sports*)
- Cleared only for *contact/endurance sports and other sports*
- Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

- Cleared for ALL, but with recommendations for further evaluation or treatment for _____
- Above clearance to be granted only after _____
- Clearance cannot be given at this time because _____

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ORTHOPEDIC SCREENING GUIDE**

Athletic Activity (Instructions)	Observation
Stand Facing Examiner	General habitus; acromioclavicular joints
Look at ceiling, floor, over both shoulders; touch ears to shoulders	Cervical spine motion
Shrug shoulders (examiner resists)	Trapezius strength
Abduct shoulder 90 degrees (examiner resists at 90 degrees)	Deltoid strength
Full external rotation of arms	Shoulder motion
Flex and extend elbows	Elbow motion
Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists	Elbow and wrist motion
Spread fingers; make fist	Hand or finger motion and deformities
Tighten (contact) quadriceps; relax quadriceps	Symmetry and knee effusion; ankle effusion
"Duck walk" four steps (away from the examiner with buttocks on heels)	Hip, knee and ankle motion
Back to examiner; knees straight, touch toes	Shoulder symmetry; scoliosis, hip motion, hamstring tightness
Raise up on toes, raise heels	Calf symmetry, leg strength

May require reflex hammer, tape measure, pin, and examination table.



**SOUTH DAKOTA HIGH SCHOOL
ACTIVITIES ASSOCIATION
PHYSICAL EXAMINATION FORM**

Date Exam Expires: August 1, 2020
Check Appropriate Physical Exam Term:
 Annual Biennial Triennial

NAME _____ GRADE _____ DATE OF BIRTH _____
CHECK ONE: MALE FEMALE (2019-20 School Year)

1. Blood pressure (sitting) _____ / _____ Repeat in 5 minutes, if elevated _____ / _____.

2. Height _____

3. Weight _____

4. Vision 20/ _____ (L) 20/ _____ (R)

5. Head _____

6. Mouth (dentures, braces?) _____

7. Eyes (contacts?) _____

8. Chest/lung _____

9. Heart

a. Heart sounds _____

b. Murmurs _____

c. pulse (rad. vs fem.) _____

d. rhythm _____

10. Abdomen

a. liver or spleen _____

b. masses _____

11. Genitalia (males only)

a. hernias _____

b. testes _____

12. Orthopedic

a. cervical spine _____

b. shoulder shrug _____

c. deltoid _____

d. arms/elbow _____

e. hands _____

f. hips _____

g. knees _____

h. ankles _____

i. Scoliosis _____

Normal

Abnormal

COMMENTS

SPORTS PARTICIPATION RECOMMENDED FOR:

- _____ Cleared for ALL (*collision, contact/endurance sports, and other sports*)
- _____ Cleared only for *contact/endurance sports and other sports*
- _____ Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

- _____ Cleared for ALL, but with recommendations for further evaluation or treatment for _____
- _____ Above clearance to be granted only after _____
- _____ Clearance cannot be given at this time because _____

NAME OF EXAMINER (PRINT) _____ DATE _____, 20____

SIGNATURE OF EXAMINER _____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM**

School Year: 2019-2020

Name of High School: ELK POINT - JEFFERSON

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, 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 SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. *If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.*

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____ day of _____, 20____

Name of Student (Print Name)

Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20____

Parent/Guardian (Print Name)

Parent/Guardian Signature

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR
INSPECTION AT THE SCHOOL**

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Student Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2020.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

Signature of Parent

Date

Signature of Student (If Over 18)

*or will turn 18 during the
2019-20 school year*

Date

This form must be completed annually and must be available for inspection at the school

CONCUSSION FACT SHEET FOR ATHLETES

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
 - The right equipment for the game, position, or activity
 - Worn correctly and the correct size and fit
 - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

It's better to miss one game than the whole season.

Student's Name (please print) _____ Date: _____

Student's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

CONCUSSION FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> • Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes • Can't recall events prior to hit or fall • Can't recall events after hit or fall 	<ul style="list-style-type: none"> • Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) _____ Date _____, 20____

Parent/Guardian's Signature _____ Date _____, 20____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

ELK POINT-JEFFERSON SCHOOL
Member of the South Dakota HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2019-2020 School Year

who was born at _____
City, Town, County, State

on _____ to compete in SDHSAA approved athletics for **Elk Point-Jefferson** High School during
Date of Birth
the 2019-2020 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date _____ Signed _____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

ELK POINT-JEFFERSON
CONSENT FOR MEDICAL TREATMENT (2019-2020 School Year)

I am the (Mother, Father, Legal Guardian) of _____,
who participates in extra-curricular activities for Elk Point-Jefferson. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the Elk Point-Jefferson School District while on a school-sponsored activity. I hereby appoint said employee to act on my behalf in securing necessary medical services from any duly licensed physician. This consent is good only for the 2019-2020 school year.

Parent Signature _____

Student Signature _____

This authorization expires on August 1, 2020

Insurance Carrier _____ Policy # _____

Insurance Carrier's phone number _____

Primary Physician _____ Phone _____

Medical Alerts: