OMAHA PUBLIC SCHOOLS
7TH GRADE PHYSICAL SCREENING EXAM

The Nebraska State School Law, in part, requires a physical exam for entrance into seventh grade. A complete dental check-up is strongly encouraged at this time also.

If you do not wish to provide evidence of a physical exam, a signed statement waiving this requirement must be submitted to the school by November 1 (or 60 days after enrollment). Please note, if your child will be participating in competitive athletics, a physical examination by a licensed health care provider is required and signing a waiver does not satisfy this requirement.

Physical Education Restrictions/Exemptions: Middle or high school students who have restrictions for participation in PE must have a health care provider's order on file, delineating what the restrictions are. Students who cannot participate because of health related concerns must have a health care provider's note on file exempting them from the class.

The following forms are necessary for a 7th grade physical: The Health Exam Card and Preparticipation History Form are necessary for a school physical only. The Athletic Insurance Coverage, NSAA/OPS Student/Parent Consent, Head Injury/Concussion Acknowledgement, Concussion Information and Fact Sheet, and Guidelines for Concussion Management are necessary for participation in after-school sports.

Athletic physicals are necessary for anyone participating in an after-school sport. Having the Preparticipation History Form filled out in advance by the student and parent will not cause a delay should your student choose to participate in a sport at a later date.

History Form to be completed/signed by student **before** 7th grade physical with review and sign off by parent for possible future athletic participation. Health care provider completes Health Exam Card and reviews History Form. For participation in after-school sports, Insurance and Consent Form completed by student and parent. The Head Injury/Concussion Acknowledgement is to be reviewed and signed by student and parent.

OMAHA PUBLIC SCHOOLS – Student Form

ATHLETIC INSURANCE COVERAGE

Your school, acting for members of the athletic squad, makes available an Athletic Injury Benefit Plan approved by the Omaha Board of Education. The total premium is paid by the student or parent. The purpose of such coverage is to assist in the cost of treatment of accidental injury. Payments are in addition to any payments by another company for the same injury.

SQUAD MEMBERS MUST HAVE INSURANCE COVERAGE TO PARTICIPATE.

Check the statements that apply:

_____ I shall participate in the Athletic Benefit Injury Plan. Information brochures, if not attached, are available from the school office upon request.

_____ I have accident injury coverage with the _____ Insurance Company.

POLICY NO. _____ Signature of Parent/Guardian_____

Date _____ Address_____

Note: This form is to be filled out completely and filed in the office of the school before student is allowed to practice and/or compete.

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ **Sex** _____ **Age** _____ **Date of Birth** _____

Grade _____ **School** _____ **Sport(s)** _____

Address _____ **Phone** _____

Personal physician _____

In case of emergency, contact

Name _____ **Relationship** _____ **Phone (H)** _____ **(W)** _____

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

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition? (like diabetes or asthma)	☐	☐
3. Are you currently taking any prescriptions or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below.	☐	☐
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below.	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below.	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Foot/toes	Ankle

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosus (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended that you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last year? _____		

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 _____

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for purposes of participation in athletics and activities.

Parent or Legal guardian signature _____ Date _____

OPS Pre-Participation Physical Exam
Supplemental Questions

Cardiovascular Health	Yes	No
1. 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: _____		
2. Do you get light headed or feel more short of breath than expected during exercise?		
3. Do you get more tired or short of breath more quickly than your friends during exercise?		
4. Has any family member or relative died of heart problems or had an unexpected or unexplained death before age 50 (including drowning, unexplained car accident, or Sudden Infant Death Syndrome)?		
5. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, Long QT Syndrome, Short QT Syndrome, Brugada Syndrome, a catecholaminergic polymorphic ventricular tachycardia?		
6. Does anyone in your family have a heart problem, pace maker, or implanted defibrillator?		
7. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Health		
8. Do you have any bone, muscle, or joint injury that bothers you?		
9. Do any of your joints become painful, swollen, feel warm, or look red?		
10. Do you have any history of juvenile arthritis or connective tissue disease?		
General Medical		
11. Have you had a herpes or MRSA skin infection?		
12. Have you had any eye injuries?		

OMAHA PUBLIC SCHOOLS
HEALTH EXAMINATION CARD

Last Name _____ First Name _____ Birthday_____ Gender: M___ F___
Address _____ Phone _____ School _____ Grade _____
Parent or Guardian's Name _____
Name of Health Care Provider _____

IMMUNIZATIONS (obtain a copy of the immunization record if possible)

Immunization Month/Day/Year

DTaP 1 _____/_____/_____
2 _____/_____/_____
3 _____/_____/_____
4 _____/_____/_____
5 _____/_____/_____

Td 1 _____/_____/_____
2 _____/_____/_____
3 _____/_____/_____

Tdap 1 _____/_____/_____
2 _____/_____/_____

VZV 1____/___/_____
2____/___/_____
Date parent reported disease_____

HPV 1____/___/____
2____/___/____
3____/___/____

Immunization Month/Day/Year

Polio 1 ___/_____/_____
2 ___/_____/_____
3 ___/_____/_____
4 ___/_____/_____
5 ___/_____/_____

MMR 1 ___/_____/_____
2 ___/_____/_____

HIB 1 ___/_____/_____
2 ___/_____/_____
3 ___/_____/_____
4 ___/_____/_____

Prevnar 1____/___/_____
2____/___/_____
3____/___/_____
4____/___/_____

Meningococcal ___/___/_____

Immunization Month/Day/Year

HEP B 1 ____/_____/_____
2 ____/_____/_____
3 ____/_____/_____
4 ____/_____/_____

HEP B 1 ____/_____/_____
(2-dose series) 2 ____/_____/_____

HEP A 1 ___/_____/_____
2 ___/_____/_____

TB skin test Result
___/_____/_____ _____

___/_____/_____ _____

Influenza ____/____/_____
____/___/_____
____/___/_____

Other _____
_____

HEALTH HISTORY

_____ Fainting _____ Head Injury _____ Asthma
_____ Seizure _____ Surgery _____ Allergies
_____Other, describe _____
_____ Family history of sudden death prior to age 50 _____

PHYSICAL EXAMINATION

General Appearance _____Height _____ Weight _____ BMI _____
Lab: HCT or HGB _____ Lead level drawn _____Yes ___ No ___ BP_____
Skeletal Development _____Posture _____ Scoliosis _____
Hair/Skin_____Lymph _____Head/Neck _____
Ears _____ Nose/Sinus _____ Throat _____
Mouth_____ Dental_____ Speech _____
Heart _____ Rhythm _____ Rate _____ Chest/Lungs _____

(over)

Abdomen _____Back _____
Extremities _____
Neurological Exam _____
Mental development assessment _____
Medical diagnosis _____
Is this child subject to any condition limiting classroom or physical activities? ___ No ___ Yes
If "Yes", describe _____
Is this child taking any medication? ___No ___Yes if "Yes", list medications _____
_____
List concerns/remarks _____
_____

HEARING SCREENING: _____Pass _____Fail Referral_____

Audio Test	500Hz	1000Hz	2000Hz	4000Hz
Right Ear---dB	_____	_____	_____	_____
Left Ear ----dB	_____	_____	_____	_____

VISION EXAM required for Kindergarten and students transferring from outside of NE

Tests	Pass	Fail	Recommend Further Examination (See Comments Below)
Amblyopia	____	____	_____
Strabismus	____	____	_____
Internal Eye Health	____	____	_____
External Eye Health	____	____	_____

Visual Acuity Right 20/_____ Left 20/_____with/without glasses

Comment/Recommendations/Restrictions_____
_____
_____

_____ _____ _____
Date of PE Signature of Licensed Health Care Provider Office Phone #

NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)/Omaha Public Schools (OPS)
Student and Parent Consent Acknowlegement and Release Form

School Year - 20____ - 20____ Member School:_____

Name of Student:_____

Date of Birth: _____ Place of Birth: _____

The undersigned(s) are the student and the parent(s), or guardian(s) in charge of the above named student and are collectively referred to as "Parent".

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;

(2) Understand and agree that (a) by this Consent Form the NSAA has provided 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 injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) even the best coaching, the use of the best protective equipment and strict observance of the rules. Injuries are still a possibility;

(3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and;

(4) Consent and agree to (a) the disclosure by the Member school at which the Student is enrolled in the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major field of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such photographs or recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

(5) Consent and agree for the above named student to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I/We authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary in the course of such athletic activities or travel.

(6) WITH FULL UNDERSTANDING OF THE RISKS INVOLVED, RELEASE, INDEMNIFY, AND HOLD HARMLESS THE OMAHA PUBLIC SCHOOLS AND ITS OFFICERS, AGENTS, REPRESENTATIVES, AND EMPLOYEES (COLLECTIVELY THE "RELEASEES") FROM ANY AND ALL LOSSES, CLAIMS, DEMANDS, ACTIONS AND CAUSES OF ACTION, OBLIGATION, DAMAGES, AND COSTS OR EXPENSES OF ANY NATURE (INCLUDING ATTORNEY'S FEES) THAT THE STUDENT AND OR PARENTAL/LEGAL GUARDIAN INCUR OR SUSTAIN TO PERSON, PROPERTY OR BOTH, WHICH ARISE OUT OF, RESULT FROM, OCCUR DURING OR ARE OTHERWISE CONNECTED WITH THE STUDENT'S PARTICIPATION IN NSAA OR OMAHA PUBLIC SCHOOLS ACTIVITIES OR TRAVEL RELATED TO SUCH ACTIVITIES IF DUE TO ACCIDENT, MISHAP, OR ORDINARY NEGLIGENCE OF THE RELEASEES.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in athletic activities and the release.

WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.

Dated this _____ day of _____, _____.

_____ _____

Name of Student [Print Name] Student Signature

(I am) (We are) the [circle the appropriate choice] (Parent) (Guardian). (I) (We) acknowledge that (I) (We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I) (We) hereby give (my) (our) permission for _____ [insert student name] to practice and compete for the above named high school/middle school in activities approved by the NSAA, except those crossed out below:

Baseball	Golf	Tennis	Debate	Speech
Basketball	Swimming	Track	Journalism	
Cross Country	Soccer	Volleyball	Music	
Football	Softball	Wrestling	Play Production	

Dated the _____ day of _____, _____.

_____ _____

Parent/Guardian [Print Name] **Parent/Guardian Signature**

OMAHA PUBLIC SCHOOLS HEAD INJURY/CONCUSSION ACKNOWLEDGEMENT FORM

I understand there is a possibility that participation in any sport may result in a head injury and/or concussion. Furthermore, I have been provided with the *Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet* and understand the importance of reporting a head injury and/or concussion tp parents, coaches and athletic training staff.

After reading the *Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet,* I am aware of the following information:

- A concussion is a brain injury, which I am responsible for reporting;
- A concussion can affect ones ability to perform everyday activities, affect reaction time, balance, sleep quality, and classroom performance;
- A student athlete will not be allowed to return to a game or practice until cleared by a physician or the OPS Athletic Training Staff;
- Following a concussion, the brain needs time to heal. There is an increased likelihood for a repeat concussion if the individual returns to play before symptoms have resolved;
- In certain instances, repeat concussion can cause permanent brain damage, even death; and
- At any point following a suspected concussion, any of the following individuals reserves the right to voice concern for the safety of a student athlete and prohibit he or she from returning to play: *physician, coach, student athlete, athletic trainier, parent*.

By signing below, I understand the importance of the statements above and have asked any, and all questions regarding the above statements. I further understand that I will not be allowed to participate in OPS athletics until this form is signed by a parent/guardian.

I hereby attest that I have read, fully understand, and will abide by the above statements.

Student Athlete Name_____

Sport(s)_____

Student Athlete Signature _____***Date***_____

Parent/Guardian Signature (required)_____***Date***_____

Guidelines For Concussion Management:

The Goals and Outcomes of the OPS Sports Medicine Advisory Committee on Concussion Management

GOAL	GOAL
To prevent increasing the severity of the injury.	To prevent re-injury through proper management.
Guideline	**Guideline**
All concussions will be assessed using guidelines established by the 2008 International Conference on Concussion in Sport. ***For complete details, please see your school's Certified Athletic Trainer.*** *BRAIN INJURIES (CONCUSSIONS) SHOULD NOT BE TAKEN LIGHTLY. ONLY THOUGH IMMEDIATE AND EARLY RECOGNITION AND PROPER MANAGEMENT, CAN WE PREVENT A POTENTIALLY LIFE ALTERING EVENT.*	1. A student athlete will be removed from a practice or game when he or she is reasonably suspected of sustaining a concussion or head injury; 2. The student athlete will be evaluated by qualified medical personnel; 3. The student athlete will not be allowed to return to play until he or she is asymtomatic and exhibit no nueropsychological or nuerocognitive deficits during follow-up ImPact Testing; and 4. The student athlete will not be allowed to return to practice or competition until he or she has been cleared by a physician or OPS Certified Athletic Trainer and has completed a medically supervised stepwise return to play progression. ***For complete details, please see your school's Certified Athletic Trainer.***

If your son or daughter has sustained a concussion:

1. Seek medical attention (physician, ER, athletic trainer)
2. Keep them out of play
3. Tell all athletic trainers and coaches about any previous or current concussions

Source: Center for Desease Control (www.cdc.gov)

Resources for information on concussions and this policy may be found:

1. Center for Desease Control **www.cdc.gov**
2. Omaha Public Schools website **www.ops.org**
3. National Athletic Trainers Association **www.nata.org**
4. National Federation of State High Schools Association **www.nfhs.org**

~ What to Do if You Suspect Your Child Has Suffered a Concussion ~

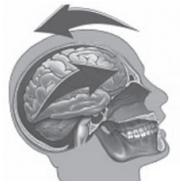
A student athlete should be taken to the emergency (ER) department if any of the following signs or symptoms are present.

- Headaches that worsen
- Seizures
- Looks very drowsy and cannot be awakened
- Repeated vomiting
- Slurred speech
- Cannot recognize people or places
- Increasing confusion or irritability
- Weakness or numbness in arms or legs
- Neck pain
- Unusual behavior change
- Any loss of consciouness
- Any symptoms that worsen or do not improve over time
- Increase in the number of symptoms
- Symptoms which begin to interfere with the student's daily activities

• • • Parent/Guardian Keep This Sheet • • •

Omaha Public Schools Sports Medicine Advisory Committee
Parent and Student Athlete Concussion Information and Fact Sheet

In the fall of 2008, the Certified Athletic Trainers and Physicians working with OPS began utilizing new guidelines to evaluate, assess, and manage concussions incurred by OPS student athletes. Since then the guidelines have been reviewed and updated annually to reflect emerging best practices in the recognition and management of concussions in youth sports.



Concussions may result from sudden trauma, such as sports injuries, that cause the brain to hit the inside of the skull.

Did You Know?

According to the Center for Disease Control and other publications:

- Each year 300,000 athletes suffer sports-related concussions.
- The national estimate for concussions in high school athletes is 136,000.
- In ages 15-24, sports are the 2nd leading cause of traumatic brain injury.
- Most studies done on concussions focus on the "mature" brain and thus, we cannot ignore the fact that the young brain is still developing and the effects of concussions are not fully understood.
- High school athletes who sustain a concussion demonstrate prolonged memory dysfunction compared with college athletes.
- A concussion is: "getting your bell rung," and "getting dinged."
- Failure to recognize and properly manage a concussion can lead to a catastrophic injury known as "second impact syndrome."
- Second impact syndrome can be catastrophic, even fatal.
- Second impact syndrome is preventable – if concussions are recognized and properly managed.
- On April 18, 2011, LB 260 – "The Concussion Awareness Act" was signed into law with the intent to protect the youth participating in athletics across the state from the dangers of concussions that are often unrecognized, undiagnosed, and/or mismanaged.

According to a study by McCrea published in 2004, ***The top reasons for athletes not reporting concussions were:***

1. Didn't think the concussion was serious.
2. Didn't want to leave the game.
3. Didn't realize a concussion was sustained.
4. Didn't want to let down their teammates.

Sources:

1. Center for Disease Control, "Heads Up: Concussion in High School Sports." www.cdc.gov

2. Gessel, LM et al. Concussions Among US High School and College Athletes. Journal of Athletic Training. 2007: 43(4): 495-203

3. Guskiewicz, KM et al. NATA Position Statement: Management of Sports Related Concussions. Journal of Athletic Training. 2004: 39(3) 280-297

WHAT DOES A CONCUSSION LOOK LIKE?

SIGNS:	*SYMPTOMS:*
1. Appears dazed or stunned	1. Headache or "pressure" in the head
2. Is confused about an assignment	2. Nausea
3. Forgets plays	3. Balance problems or dizziness
4. Moves clumsily or displays problems with balance and coordination	4. Double or fuzzy vision
5. Loses consciousness (even briefly)	5. Sensitivity to light or noise
6. Shows behavioral of personality changes	6. Feeling slowed down, foggy, or groggy
	7. Does not "feel right"