PRE-PARTICIPATION PHYSICAL EVALUATION

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 the MSHSAA any and all portions of school record files, 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)	
We have received and read the MSHSAA materials on Concussion, which includes information on the definition of a concussion, symptoms of a concussion, what to do if you have a concussion, and how to prevent a concussion.	
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

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

Patient may:
- ✓ Have contact with children (infant through school-age) in care away from their own homes.
- ✓ Be responsible for children's physical care and social development during day and/or nighttime hours.
- ✓ Need to lift children.

IDENTIFYING INFORMATION (To be completed by patient.)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER
	( )

NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED

MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)

PHYSICAL EXAMINATION

On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. ☐ Yes ☐ No

TB CLEARANCE

(Check one.)

☐ TB Risk Assessment Form attached (required)

☐ A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____ .

LIMITATIONS

The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children:

☐ None

☐ _____

RESTRICTIONS

This patient has the following restrictions, e.g., cannot lift children who weigh more than 20 pounds, etc.

☐ None

☐ _____

REMARKS

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)
NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE)		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.)
		TELEPHONE NUMBER ( )

THIS FORM IS TO BE KEPT ON FILE AT THE CHILD CARE FACILITY

PRE-PARTICIPATION PHYSICAL EVALUATION

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