Warren County School District

Curwen Building • 185 Hospital Drive
Warren, Pennsylvania 16365
Phone: 814/723-6900 • Fax: 814/726-1060
www.wcsdpa.org

John H. Grant
Superintendent
john.grant@wcsdpa.org

Dear Parents / Guardians:

We are pleased that your son or daughter has expressed an interest in athletics. We feel that involvement in co-curricular activities and athletics in particular enhances a child's education. However, it is imperative that your child is in good health if he/she is to participate safely.

Attached please find a Pre-Participation Sports Physical Evaluation form. That document will be completed by a medical professional. **The remainder of the packet is to be completed by the student's parent or guardian.** The four (4) – page Health Record and Questionnaire and the Parent/Guardian Consent form provide vital information to health care personnel about your child as well as consent and insurance information. Finally, the last page outlines our compliance with "HIPAA". **Please take the time to complete the Health Record and Questionnaire and the Parent/Guardian Consent forms as they are required to insure your child's safe participation.**

Thank you.

Sincerely,

John N. Werner
Supervisor
District-Wide Athletics and Co-Curricular Activities

JNW

MISSION STATEMENT

The mission of the Warren County School District is to prepare all students to be responsible and productive citizens by providing them with the skills and education necessary to achieve academic and personal excellence.

HEALTH RECORD AND QUESTIONNAIRE
PARENT/GUARDIAN CONSENT

Pages 1-4 must be completed and signed by parent or guardian

Date:_____

PERSONAL INFORMATION

Name_____Date of Birth_____Age on Last Birthday_____

Current Address_____

Current Phone # ( )_____ Enrolled in _____School

Family Physician_____ Address/Phone #_____

GENERAL INFORMATION

Does the student have or have a history of the following:

YES	NO		YES	NO	
☐	☐	Asthma _____	☐	☐	Cancer _____
☐	☐	Diabetes _____	☐	☐	Allergies _____
☐	☐	Heart Problems_____	☐	☐	Medication _____
☐	☐	Dizziness _____	☐	☐	Food _____
☐	☐	Chest Pain/Angina _____	☐	☐	Bites/Stings _____
☐	☐	Extra Heart Beat _____	☐	☐	High Blood Pressure _____
☐	☐	Blackouts/Loss of Consciousness_____	☐	☐	Infectious Mononucleosis (Mono) _____
☐	☐	Rheumatic Fever_____	☐	☐	Skin Problems (itching, rashes, or acne) _____
☐	☐	Drug or Alcohol Problems _____			
☐	☐	Cysts or Lumps _____	☐	☐	Does the student wear glasses or contact lenses? _____
☐	☐	Hepatitis _____			
☐	☐	Loss of Paired Organ (i.e. eye, testicle)	☐	☐	Does the student take any medications? If so, over-the-counter, prescription, herbal or dietary supplements? (circle all that apply) Medications:_____
☐	☐	Heat Cramps/Exhaustion/Stroke _____			
☐	☐	Does the student have any special protective equipment needs? _____			
☐	☐	Has the student ever used anabolic steroids? _____	☐	☐	Has the student ever had surgery? If so, when and what: _____ _____
☐	☐	Has the student ever used extreme measures to avoid weight gain or loss? _____			
☐	☐	Weight change in last six months?_____ How Much _____ Up or Down _____	☐	☐	Has the student ever had varicella (chicken pox)? When was the student's last tetanus shot? _____ Measles shot x2? _____ Hepatitis B. Vaccination x3? _____

Name: _____

ABDOMINAL

Does the student have or have a history of the following:

YES	NO	
☐	☐	Appendicitis _____
☐	☐	Stomach Trouble _____
☐	☐	Bleeding from Rectum _____
☐	☐	Injury to Spleen _____
☐	☐	Hernia _____
☐	☐	Injury to Kidney _____

Are the following organs intact and normal as far as you know? Indicate the absence of organs:

YES	NO	
☐	☐	Lungs _____
☐	☐	Kidneys _____
☐	☐	Testes _____
☐	☐	Eyes _____
☐	☐	Ears _____

EAR-NOSE-THROAT

Does the student have or have a history of the following:

YES	NO	
☐	☐	Hearing Difficulty _____
☐	☐	Frequent Earaches _____
☐	☐	Problems Breathing through Nose _____
☐	☐	Broken Nose _____
☐	☐	Frequent Tonsil Infections _____
☐	☐	Cough after or during Exercise _____

DENTAL

Does the student have or have a history of the following:

YES	NO	
☐	☐	Cavities _____
☐	☐	False Teeth _____
☐	☐	Many Toothaches _____
☐	☐	Missing Teeth _____
☐	☐	Does the student have a dentist? _____

NEUROLOGICAL

Does the student have or have a history of the following:

YES	NO	
		Head Injury
☐	☐	Skull Facture _____
		How many concussions total? _____
☐	☐	Concussions (memory loss, headache, confusion, nausea) _____
		Last concussion was _____ months ago.
		How long did concussion last? _____
☐	☐	Unconsciousness _____
		How long did unconsciousness last? _____ minutes/seconds
☐	☐	**Neck Injury** _____
		Facture _____
		What spinal level? _____
☐	☐	Pinched Nerve (Burner or Stingers) _____
		Left _____ or Right _____ or Both _____
☐	☐	Frequent Headaches _____
		How often? _____
☐	☐	Seizure Disorder _____
☐	☐	Depression or Anxiety _____

Name: _____

FEMALES

YES NO

☐ ☐ Does the student have a history of a eating disorder? _____
First menstrual period was at age_____
Last menstrual period was _____ days ago.
The longest time between periods over the
The last year was _____ months.
Periods last _____ days.

☐ ☐ Is the student pregnant? _____

FAMILY HEALTH HISTORY

Has any member of the student's family died from or now have any of the following:

YES NO

☐ ☐ Died Suddenly _____
☐ ☐ Heart Disease _____
☐ ☐ Diabetes _____
☐ ☐ High Blood Pressure _____
☐ ☐ Seizure Disorder_____
☐ ☐ Sickle Cell Trait/Disease _____
☐ ☐ Has the student had any other medical conditions not listed?

If yes, explain_____

ORTHOPEDIC

Does the student have or have a history of any injury to any of the following? Please explain whether injury was right or left, indicate the month and year of injury and if the student fully recovered from the injury:

YES NO

Cervical Spine

☐ ☐ Fracture _____
☐ ☐ Pinched Nerve _____
☐ ☐ Stinger/Burner _____

Thoracic Region

☐ ☐ Upper Back_____
☐ ☐ Chest, Ribs _____

Lumbar Spine (Lower Back)

☐ ☐ Muscle Spasm, Strain_____
☐ ☐ Fracture or other_____
☐ ☐ Shoulders _____
☐ ☐ Upper Arm/Elbow _____
☐ ☐ Forearm/Wrist _____
☐ ☐ Diagnostic Tests: _____
Bone Scan _____
CAT Scan _____
MRI Scan _____
X-Rays _____
Ultrasound _____
Other _____

YES NO

☐ ☐ Hand/Fingers _____
☐ ☐ Pelvis/Hip/Groin _____
☐ ☐ Thigh: Quadriceps_____
☐ ☐ Hamstrings _____
☐ ☐ Other_____
☐ ☐ Knees _____
☐ ☐ Lower Leg/Ankle _____
☐ ☐ Calf/Shin _____
☐ ☐ Achilles Tendon _____
☐ ☐ Ankle _____
☐ ☐ Foot/Toes _____

☐ ☐ Has the student had any other injuries to bones, joints, muscles or nerves (dislocation, tendonitis, calcium deposits, fractures, spurs, etc.) not listed herein?

If yes, explain

_____
_____
_____

DISCLAIMER

I give my consent for the herein named student _____ born on _____who turned _____on his/her last birthday, a student of _____School and a resident of the Warren County Public School District, to commence Practice and participate in Inter-School Practices or Scrimmages and Contests During the _____school year in the sport(s) of _____ as indicated by my signature.

Signature of Parent or Guardian: _____

I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices or Scrimmages and Contests involving PIAA member schools. Such requirements include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Signature of Parent or Guardian: _____

To enable PIAA to determine whether the herein named student _____ is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the 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, health records, academic work completed, grades received, and attendance data.

I further consent to PIAA's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices or Scrimmages and Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Signature of Parent or Guardian: _____

Students who voluntarily participate in the school athletic programs are responsible for obtaining insurance coverage for any medical costs incurred as a result of the sports participation. If your child is out for a sport, the following form must be completed.

STUDENT ACCIDENT INSURANCE

_____

(Athlete's name)

is adequately covered by accident insurance for sports participation.

_____

(Parent/Guardian Signature)

_____

(Date)

ACKNOWLEDGMENT OF RISK AND CONSENT TO PARTICIPATE

I hereby acknowledge an awareness that participation in _____ involves a risk of injury, which may include severe injuries possibly involving paralysis, permanent mental disability, or death and that these injuries may occur in some instances as the result of unavoidable accidents. We accept these risks in giving consent to participate in the above sport during the 2005/2006 season by the undersigned athlete.

_____

(Athlete's Signature)

_____

(Parent/Guardian Signature)

_____

(Date)

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John H. Grant
Superintendent
john.grant@wcsdpa.org

MEMORANDUM

TO: Athletics Participants and Parents

FROM: High School Principals/Warren County School District

SUBJECT: Authorization to Use and Disclose Information

A federal law, the Health Insurance Portability and Accountability Act ("HIPAA"), is changing the way we deliver health services. That Act establishes privacy rights concerning an individual's health information. Under that Act, the athletic trainer cannot communicate medical information to School District staff without written authorization from the student's parent/guardian.

As you probably know, the School District and Warren General Hospital have been working together to provide an athletic trainer to help with student safety in athletics. The athletic trainer attends various practices and events and works with students and coaches to give training and safety advice and to help assess injuries and fitness for participation as described by the attending physician. Up until now, the athletic trainer, coach, and School District were able to get the necessary injury information on a student athlete from the physician and Warren General.

The attached form gives the parent/guardian two options from which to choose. While you are not required to choose either option, your student will not be able to participate in the District athletic program if the form is not signed.

Checking Option A on the attached form by the parent/guardian will allow medical information to be shared between the athletic trainer and/or physician and coaching staff, athletic coordinator, building principal, and the school nurse as we presently do.

Checking Option B on the attached form will not allow authorization to disclose the student athlete's health information. It is understood that if the student athlete is under a physician's care and cannot practice, the student athlete cannot return to practice without a written statement from the physician and the parent/guardian to release the student athlete to return to practice.

The student athlete cannot participate in athletics until the form is returned with the physical card.

Questions:
Contact person(s): High School Principals
Mark Eberl, Director of Human Services, Warren County School District Compliance Officer/723-6900
Alice Pedersen, Director of Compliance, Warren General Hospital/723-4973 Ext. 1507
John Werner, Supervisor of District-Wide Athletics and Co-Curricular Activities, Warren County School District/723-6900

Authorization for the Use or Disclosure of Protected Health Information
Warren General Hospital-Warren County School District Athletics Program
2 Crescent Park P.O. Box 68, Warren, PA 16365

AUTHORIZATION FORM

For the purpose of determination of playing/participation status for the duration of the current school year

Name (Student Athlete):

_____

Date of Birth:

_____

- Oral communication concerning condition and ability to participate
- Emergency room report
- Reports of diagnostic tests
- Physical therapy and other rehabilitation reports
- All other medical information related to student's ability to participate in sports

- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and will no longer be protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Privacy Officer, Warren General Hospital, 2 Crescent Park P.O. Box 68, Warren, PA 16365. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
- I understand that this authorization will automatically expire: at the end of the current school year.
- I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

OPTION A: Your signature indicates that you authorize the athletic trainer and/or physician the use and disclosure of the following protected health information described herein for the student athlete and authorize the coaching staff, athletic coordinator, building principal, and the school nurse to receive these disclosures as we presently do:

_____ _____
Signature (Student Athlete) Date

_____ _____ _____
Signature (Parent/Guardian) Relationship to Patient Date

OPTION B: Your signature indicates you do NOT authorize the athletic trainer or physician to disclose the student athlete's health information to the coaching staff. It is understood that if the student athlete is under a physician's care and cannot practice, the student athlete cannot return to practice without a written statement from the physician and the parent/guardian to release the student athlete to return to practice.

_____ _____
Signature (Student Athlete) Date

_____ _____ _____
Signature (Parent/Guardian) Relationship to Patient Date

If you choose to revoke your selection of Option A or Option B, please contact the principal for a new form.