

# HINGHAM HIGH SCHOOL

## Sport Candidate Clearance/Emergency Treatment Consent Form (Form A)

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Student Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Sex: \_\_\_\_\_ List all sports interested in playing: \_\_\_\_\_

Grade in September, 2011: \_\_\_\_\_ Date student first entered high school? \_\_\_\_/\_\_\_\_/\_\_\_\_

School(s) attended in 2010 - 2011: \_\_\_\_\_

1. Is your child **CURRENTLY** being treated for any of the following? Please circle "Y" for Yes or "N" for No and provide details where indicated.

Arthritis or joint disease	Y	N	Hepatitis	Y	N
Asthma	Y	N	Heat stroke or heat exhaustion	Y	N
Blood disorder	Y	N	Kidney disease	Y	N
Compromised immune system	Y	N	Life threatening allergy	Y	N
Concussion (see below)	Y	N	Allergen _____		
Diabetes	Y	N	Mononucleosis	Y	N
Fainting spells	Y	N	Seizures	Y	N
Head injury	Y	N	Other _____	Y	N

Explain any "Yes" answers:

Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Has student ever experienced a traumatic head injury (blow to the head)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Dates (month/year): \_\_\_\_\_

Has student ever received medical attention for a head injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Dates (month/year): \_\_\_\_\_

If yes, please describe the circumstances: \_\_\_\_\_

Was student diagnosed with a concussion? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: \_\_\_\_\_

2. Does your child require an EPI-PEN or inhaler? (circle) Y N If yes, written doctor's orders and the EPI-PEN/inhaler must be provided before the student may participate in athletics.

3. List medications child takes: \_\_\_\_\_

4. Does your child wear glasses or contacts? (circle) Y N

5. Date of child's last tetanus booster: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

<b>Parent/Guardian #1</b> Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____	<b>Parent/Guardian #2</b> Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____
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<b>Physician</b> Name: _____ Phone: _____	<b>Emergency Contact</b> Name: _____ Phone: _____
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### Concussion Information

Hingham High School offers the ImPACT Baseline Concussion Screening to all student-athletes. In addition to ImPACT, the Commonwealth of Massachusetts requires that **all athletes and parents or guardians** take an online concussion course each year. These are the links for the courses:

[http://www.cdc.gov/concussion/HeadsUp/online\\_training.html](http://www.cdc.gov/concussion/HeadsUp/online_training.html)

<http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000>

I acknowledge that I have taken the online concussion screening course.

\_\_\_\_\_  
**Student-Athlete Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

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### Parent/Guardian Permission

I hereby give permission for my child to participate in Hingham High School athletics. Hingham Public Schools and its athletic trainers and coaches have my permission to seek necessary emergency treatment for my daughter/son, during her/his participation in athletics, practices, games and conditioning workouts. I understand it is my responsibility to provide an EPI-PEN and/or inhaler and written doctor's orders, if needed, for my child. I also agree to allow my child to participate in ImPACT concussion screening. This permission remains in effect for this academic year only.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**