AUTHORIZATION TO RELEASE MEDICAL INFORMATION RELATING TO STUDENT HEALTH REVIEW/EXAM

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

_____/_____/_____

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

_____/_____/_____

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

_____/_____/_____

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam** (_____/_____/_____)

Are your immunizations up to date ☐ Yes ☐ No | **Last tetanus shot** (_____/_____/____) | **Last measles shot** (_____/_____/___) | **Last TB skin test** (_____/_____/___)

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
2.	Have you ever had surgery?	☐	☐
3.	Are you presently taking any medications or pills?	☐	☐
4.	Have you ever passed out during or after exercise?	☐	☐
5.	Have you ever been dizzy during or after exercise?	☐	☐
6.	Have you ever had chest pain during or after exercise?	☐	☐
7.	Do you tire more quickly than your friends during exercise?	☐	☐
8.	Have you ever had high blood pressure?	☐	☐
9.	Have you ever been told that you have a heart murmur?	☐	☐
10.	Have you ever had racing of your heart or skipped beats?	☐	☐
11.	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
12.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
13.	Have you ever had a head injury?	☐	☐
14.	Have you ever had a concussion? If yes, how many_____	☐	☐
15.	Have you ever been knocked out or unconscious?	☐	☐
16.	Do you suffer from migraines?	☐	☐
17.	Have you ever had a seizure?	☐	☐
18.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
19.	Have you ever had heat or muscle cramps?	☐	☐
20.	Have you ever been dizzy or passed out in the heat?	☐	☐
21.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
22.	Do you use any special equipment *(pads, braces, neck rolls, mouth guards, eye guards, etc.)*?	☐	☐
23.	Have you ever had problems with your eyes or vision?	☐	☐
24.	Do you wear glasses or contacts or protective eye wear?	☐	☐
25.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand	☐	☐
26.	Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*?	☐	☐
27.	Have you had any medical problem or injury since your last evaluation?	☐	☐
28.	Are you Diabetic?	☐	☐
29.	Are you Asthmatic?	☐	☐
30.	Do you have any allergies *(medicine, bees or other stinging insects)*??	☐	☐

List all allergies: _____

31. When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

32. Explain all "yes" answers: _____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

ALASKA SCHOOL ACTIVITIES ASSOCIATION, INC.
4048 Laurel Street, Suite 203 • Anchorage, AK 99508 • (907) 563-3723 • Fax 561-0720 • www.asaa.org

STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant or advanced nurse practitioner

This form to be sent to the school (do not send to ASAA)

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

_____/_____/_____

Height | **Weight** | **Blood Pressure** | **Pulse**

Vision — Right Eye 20/ | **Vision — Left Eye** 20/ | **Vision Corrected?** ☐ Yes ☐ No | **Pupils**

	NORMAL	ABNORMAL FINDINGS	INITIALS
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

☐ Cleared

☐ Cleared after completed evaluation/rehabilitations for (Specific Sports): _____

☐ Not cleared for: ☐ Collision ☐ Contact ☐ Noncontact ☐ Strenuous ☐ Moderately Strenuous ☐ Nonstrenuous

Due to: _____

_____

Name of M.D., P.A. or ANP (circle which) | **Signature** | **Date**

_____/_____/_____

Address | **Phone**

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