

RLCS Athletics Participation Permission Slip 2024-2025



Dear Parent/Guardian:

Thank you for your interest in RLCS Athletics. Please fill out this permission slip and return it to the school indicating your consent to your child's participation in any of RLCS' athletic programs.

_____	_____	_____
Child's Name	Age	Current Grade
_____	_____	_____
Address	City	State Zip
_____	_____	
Parent/Guardian	Emergency Phone	
_____	_____	
Insurance Company	Policy #	

Significant Health Concerns

Recent* Physical Examination

_____	_____
Date of Exam	Name of Doctor

*The physical examination may not exceed one year prior to the date of the signing of this permission slip.

I hereby grant permission for my child to participate in RLCS Athletics and to be treated by a licensed physician or staff member in the event of any injury, illness or other mishap during the course of his/her participation. My child understands that he/she will be engaging in physical activity during the program that contains inherent risk of physical injury. RLCS, the director or staff, will not be held liable for personal injury occurring as a result of the applicant's participation in the activities that comprise RLCS Athletics.

I have also reviewed and understand the sudden cardiac arrest (SCA) and concussion information sheets.

Parent/Guardian's Signature

Date



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____
 Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)
 Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: ()				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TESTS	DATE	DATE

(Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

HEALTH CARE PROVIDER'S NAME (Print name, use this information unless you prefer to record the immunization provider's name): _____

IMMUNIZATION EXEMPTION(S):

- Medical Date issued: _____ Reason: _____ Date Rescinded: _____
- Medical Date issued: _____ Reason: _____ Date Rescinded: _____
- Medical Date issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT					
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td					
Polio Type: OPV or IPV					
Hepatitis B (HepB)					
Measles/Mumps/Rubella (MMR)					
Mumps disease diagnosed by physician <input type="checkbox"/> Date: _____					
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>					
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella					
Meningococcal Conjugate Vaccine (MCV4)					
Human Papilloma Virus (HPV) Type: HPV2 or HPV4					
Influenza Type: TIV (injected) LAIV (nasal)					
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)					
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13					
Hepatitis A (HepA)					
Rotavirus					
Other Vaccines: (Type and Date)					

Sudden Cardiac Arrest / Concussion Information Sheet

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA is not a heart attack. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- Fainting or seizures during exercise;
- Unexplained shortness of breath;
- Dizziness;
- Extreme fatigue;
- Chest pains; or
- Racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What is a concussion?

A concussion is a type of traumatic brain injury that disrupts normal functioning of the brain. A concussion can be caused by a bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

Why should a student-athlete report their symptoms?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion.

Repeat concussions can increase the time it takes to recover.

In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.

Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.

Second impact syndrome can lead to severe impairment and even death in extreme cases.

Quick facts:

Most concussions do not involve loss of consciousness.
Athletes who have, at any point in their lives, had a concussion have an increased risk of another concussion.
Young children and teens are more likely to get a concussion and take longer to recover than adults.
You can sustain a concussion even if you do not hit your head.
A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion.
Signs and symptoms of a concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

Danger signs:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

One pupil larger than the other.
Is drowsy or cannot be awakened.
A headache that not only does not diminish, but gets worse.
Weakness, numbness, or decreased coordination.
Repeated vomiting or nausea.
Slurred speech.
Convulsions or seizures.
Cannot recognize people or places.
Becomes increasingly confused, restless, or agitated.
Has unusual behavior.
Loses consciousness (even a brief loss of consciousness should be taken seriously).

Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer. It's better to miss one game than the whole season.