Durham Public Schools
Assumptions of Risk/Medical Treatment Release

Student – Athlete Name ____________________________________________________________________
School __________________________________________________________________________________
Sport(s) ___________________________________________________________ Date_____________________________

The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics.
By signing below, I understand:
1. The Rules and procedures of the sport listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and hereby give my permission for my son/daughter to participate in any and all interscholastic events sponsored by Durham Public Schools.

Permission is hereby granted to Durham Public Schools and its authorized representatives to initiate treatment and rehabilitation of injuries and authorize any needed major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participating by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named individual may be given.

I hereby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including, but not limited to, its coaches, certified athletic trainers, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools and do hereby agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Are you presently taking any medications, supplements, or pills?  Yes ___  No ___
If yes, please list: __________________________________________________________

Does student named above have allergies?  Yes ___  No ___
(medicines, bee stings, hay fever, etc)
If yes, please list: __________________________________________________________
Phone # Primary ________________________Secondary ________________________
Cell ______________________

Emergency Contact: Name __________________________________________________
Primary # ________________________ Secondary ________________________

Signature: (Parent/Guardian): __________________________________ Date__________________
Durham Public Schools
Medical History Athletic Participation Form

This form should be completed by parent or guardian prior to the physical examination and taken to the physician for review when the physical examination is given.

Student Information:
Name: _______________________________________________________ Grade_______
Address: _____________________________________________________________
City: _________________________________________________________________
State: _____________________ Zip: __________________________
I intend to play the following sport(s): _______________________________________

I certify that all the information is correct, and I agree to abide by the eligibility rules and regulations of my school and the North Carolina High School Athletic Association.

Parent/Guardian Information:
Name:_______________________________________ Relationship:_________________
Telephone Numbers: _______________________________________________________
Home Work Cell
Emergency Contact: _______________________________________________________
Home Work Cell

Student’s Physician:_________________________________________________________
Address of Attending Physician Phone Number

Student’s Social Security Number: ______________________ Date of Birth: _____________

Please explain any answers to questions 1-15 in the “yes” column below.
Yes  No
___ ___  Have you ever had any of the following?
 Broken bones ______ weak joints-ankles, knees ______ spinal injury ______
 Seizures or epilepsy ______ concussions ______ operation ______
 Shoulder or neck pain such as a “burner” or “stinger”
___ ___  Injury or illness that excluded athletic participation previously
___ ___  Heat or muscle cramps

Cardiovascular History:
___ ___  Have you ever fainted or passed out?
___ ___  Have you ever had a chest pain or discomfort with exercise?
___ ___  Have you ever had to stop running or exercising because of chest pains or shortness of breath?
___ ___  Have you ever had excessive, unexpected or unexplained shortness of breath associated with exercise?
___ ___  Have you ever had excessive, unexpected or unexplained fatigue associated with exercise?
___ ___  Have you ever been diagnosed with a heart murmur?
___ ___  Have you ever had high blood pressure or hypertension?
___ ___  Has any family member died prematurely (before age 50) sudden – health related?
___ ___  Is there any family history of significant disability due to cardiovascular disease in a close relative less than 50 years of age?
___ ___  Do you have any specific knowledge of the occurrence of specific cardiovascular condition such as:
Hypertrophy cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Mar fan Syndrome, or clinically important arrhythmias?
___ ___  Do you get tired more quickly than you friends during exercise?
___ ___  Have you ever been knock out?
___ ___  Have you ever been hospitalized?
___ ___  Have you ever had significant allergies to:
  Bee strings
  Foods
  Medicine
  Other?
___ ___  Do you have prescription use for Adrenaline, Inhaler, or other allergy medicine?
___ ___  Do you have asthma
___ ___  Do you take any medicine/supplements regularly?
Have you had any illness lasting a week or more such as mononucleosis, etc.?

Have you had any blood disorders, including sickle cell trait, anemia, etc.?

Are you diabetic?

do you wear contact lenses, eyeglasses or dental appliance?

Do you have missing or non-functioning organs, i.e. testes, kidney, etc.?

Are you aware of any skin conditions or changes in the appearance of your skin?

Menstrual History: Have you begun menses? If yes, how regular are your cycles? ______

Have you ever missed 3 or more periods in a row? ______

Have you experienced a significant change I weight (gain or loss 10 lbs) in the last year?

Do you have any other significant change health problems?

Hepatitis B Immunization Series?

Date of last Tetanus immunization?

Explain any “yes” answer below:
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As legal parent or guardian of _______________________________, I hereby give my consent for him/her to practice and play in the sports listed above. I agree to the need for screening physical examination and certify that the medical history is accurate to the best of my knowledge. I hereby assume financial responsibility for my child in the event or injury or accident while participating in the scholastic sports.

Parent/Guardian signature: ___________________________ Date: ___________________________
Durham Public Schools  
Medical Examination Form

Athlete’s Name: ____________________________________________ Date of Birth: ________________

Height_________________ Weight_________________Blood Pressure______/_______ Pulse_________

Vision: Right 20/_____ Left 20/_____ Corrected: Yes No           School____________________________

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The following conditions are automatically considered disqualifying until medical and parental releases are obtained:

Acute infection, obvious growth retardation, diabetes, jaundice, severe visual and auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity with a function loss, history, history of convulsions or concussions, absence of one kidney, eye or testicle. This list is not intended to include all disqualifying conditions.

I certify that I have examined the above named student and that such examination reveals _______conditions/______
No conditions that would prevent this student from participating in the interscholastic sports listed.

If the student is disqualified, list reasons: ______________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Physicians Signature: _________________________ License # __________________ Date_____________________

Address: ______________________________________________ Phone: ___________________
Authorization For Release of Protected Health Information For Athletic Participating
In Durham Public Schools Athletics Program

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete’s participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as “Athlete”), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete’s medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete’s participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete’s termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools. As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete’s revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider’s receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete’s ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: ___________

Parent/Guardian Signature

Printed Name

Relationship to Athlete

Athlete’s Name - Printed

Date: ____________

Parent/Guardian Signature

Printed Name

Relationship to Athlete

Athlete’s Name - Printed
**This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parents who has the authority to act on the Athlete’s behalf. By signing this form, you as the parent/guardian or party acting in loco parents warrant that you have the legal authority to act on the Athlete’s behalf.

**The signature may be only the Athlete if the Athlete is over 18 years of age or legally emancipated person.