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

TO Medical Provider	
	s of all medical information in your possession, whether paper or electronic, relating student identified below to the school or school district in which the student is enrolled is.
Name of school or school district	
This release authorizes disclosure of this	is information to the school for purposes of the school's determining the fitness of the
I understand that the medical informatio to the school's administrators, athletic d I understand that once the information i	ical activities, including but not limited to competitive athletic events. In disclosed by the medical provider to the school may be further disclosed by the school irector and coaches of any interscholastic activities in which I seek to participate. It 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 authon this authorization.	norization in writing at any time, except to the extent action has been taken in reliance
I certify that the signatures on this release Photocopies of this release shall have t signatures on this form, unless revoked	the same authority as the original. This release will expire one year from the date of
Date of signature	Signature of student
<u> </u>	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 student's school/school district and to ap	above student, and authorize the foregoing release of medical information to the
Date of signature	Signature of parent / legal guardian
	Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

Student Last Name Student First Name City Zipcode		SECTION A: To be completed by parent or guardian.									
Address	Stu	dent Last Name	Stud	ent First Name			MI	Date o	f birth		Grade
Phone] [
Are your immunizations up to date Yes] [//_		
Are your immunizations up to date Yes	Ad	dress				. 9	City			Zipo	ode
Are your immunizations up to date Yes											
Are your immunizations up to date Yes											
YES NO 1. Have you ever been hospitalized?	Pho	one		Emergency Phone				Date o	f last physi	cal ex	xam
YES NO 1. Have you ever been hospitalized?											
YES NO 1. Have you ever been hospitalized?									/	/	
Have you ever been hospitalized?	Are	e your immunizations up to da	te	Last tetanus shot	Lc	ast m	easles	shot	Last TB :	skin t	est
1. Have you ever had surgery? 2. Have you ever had chest pain during or after exercise? 3. Are you presently taking any medications or pills? 4. Have you ever been dizzy 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 the more quickly than your friends during exercise? 8. Have you ever had high blood pressure? 9. Have you ever had high blood pressure? 10. Have you ever had high blood pressure? 11. Has anyone in your family died of heart problems or sudden death before age 50? 12. Do you have any skin problems (tiching, rashes, acne)? 13. Have you ever had a facing of your heart or skipped beats? 14. Have you ever had a facing of your heart or skipped beats? 15. Have you ever had a facing in your heart or skipped beats? 16. Do you shave any skin problems (tiching, rashes, acne)? 17. Have you ever had a concussion? If yes, how many		Yes No					,	,	,		,
1. Have you ever had surgery? 2. Have you ever had chest pain during or after exercise? 3. Are you presently taking any medications or pills? 4. Have you ever been dizzy 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 the more quickly than your friends during exercise? 8. Have you ever had high blood pressure? 9. Have you ever had high blood pressure? 10. Have you ever had high blood pressure? 11. Has anyone in your family died of heart problems or sudden death before age 50? 12. Do you have any skin problems (tiching, rashes, acne)? 13. Have you ever had a facing of your heart or skipped beats? 14. Have you ever had a facing of your heart or skipped beats? 15. Have you ever had a facing in your heart or skipped beats? 16. Do you shave any skin problems (tiching, rashes, acne)? 17. Have you ever had a concussion? If yes, how many	L				L_		_/	/	/_		_/
2. Have you ever had surgery? 4. Have you ever beassed out during or after exercise? 5. Have you ever beassed out during or after exercise? 6. Have you ever bead 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 bead 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 concussion? If yes, how many 14. Have you ever had a concussion? If yes, how many 15. Have you ever had a concussion? If yes, how many 16. How you ever had a concussion? If yes, how many 17. Have you ever had a seizure? 19. Have you ever had a seizure? 19. Have you ever had a seizure? 19. Have you ever had a seizure? 20. Have you ever had a seizure? 21. Do you bave any over had heat or muscle cramps? 22. Have you ever had heat or muscle cramps? 23. Have you ever had heat or muscle cramps? 24. Have you ever had heat or muscle cramps? 25. Have you ever had problems with your eyes or vision? 26. Have you ever had problems with your eyes or vision? 27. How you ever had problems with your eyes or vision? 28. Are you Diabetic? 29. Have you ever had other medical problem or injure since or londers and the had. 20. Have you ever had other medical problem or injury since your last evaluation? 29. Are you Ashmatic? 30. Do you have any allergies (medicine, bees or other stinging insects)?? 31. When was your last menstrual period? 32. Explain all "yes" answers: 33. When was your last menstrual period? 34. What was the longest time between your periods last year? 35. Explain all "yes" answers:											
3. Are you presently taking any medications or pills? 4. Have you ever pased out during or after exercise? 5. Have you ever been dizzy during or after exercise? 6. Have you ever been dizzy 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? 9. Have you ever been told that you have a heart murmur? 10. Have you ever had a 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 (tiching, rashes, acne!)? 13. Have you ever had a concussion? If yes, how many 14. Have you ever had a concussion? If yes, how many 15. Have you ever had a concussion? If yes, how many 16. Do you suffer from migraines? 17. Have you ever had a stinger, burner or pinched nerve? 18. Have you ever had a stinger, burner or pinched nerve? 19. Have you ever had a stinger, burner or pinched nerve? 10. Have you ever had a stinger, burner or pinched nerve? 11. Do you have trouble breathing or do you cough during or after activity? 12. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eve guards, etc.)? 23. Have you ever had one thing of you cough during or after activity? 24. Do you wear glasses or contacts or protective eye wear? 25. Have you ever had other medical problems with your eyes or vision? 26. Have you ever had other medical problems in firetions 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)?? 20. Have you had any medical problem or injury since your last evaluation? 32. Explain all "yes" answers: 1 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.		Have you ever been hospitalized?									
4. Have you ever beased out during or after exercise?		Are you presently taking any medicati	ons or pi	lls?		.] [
6. Have you ever had chest pain during or after exercise?		Have you ever passed out during or af	er exerci	ise?							
7. Do you tire more quickly than your friends during exercise?											
8. Have you ever had high blood pressure?		Do you tire more quickly than your fri	r after ex	ercise?							
9. Have you ever been told that you have a heart murmur?		Have you ever had high blood pressure	?								
11. Has anyone in your family died of heart problems or sudden death before age 50?		Have you ever been told that you have	a heart i	nurmur?							
12. Do you have any skin problems (itching, rashes, acne)?		Have you ever had racing of your hear	t or skipj et proble	ped beats?					• • • • • • • • • • • • • • • • • • • •	· · · · · -] [
13. Have you ever had a head injury?		Do you have any skin problems (<i>itchin</i>	g, rashes	s, acne)?		 		 			
15. Have you ever been knocked out or unconscious?	13.	Have you ever had a head injury?	- 								
16. Do you suffer from migraines?	14.	Have you ever had a concussion? If y	es, how r	nany						[
Have you ever had a seizure?	16.	Do you suffer from migraines?	Consciou			 		 			
Have you ever had heat or muscle cramps?	17.	Have you ever had a seizure?									
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 spained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? — HeadShoulderThighNeckElbowKneeChestForearmShin/calfBackWristAnkleHipHand 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? When was your last menstrual period? When was your last menstrual period? When was your 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:	18.	Have you ever had a stinger, burner or	pinched	nerve?] [
21. Do you have trouble breathing or do you cough during or after activity?											
23. Have you ever had problems with your eyes or vision?	21.	Do you have trouble breathing or do y	ou cough	during or after activity?							
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?	22.	Do you use any special equipment (pa	ls, brace	s, neck rolls, mouth guards,	eye gua	rds, et	c.)?				
25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? HeadShoulderThighNeckElbowKneeChestForearmShin/calfBackWristAnkleHipHand 26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.)?	24.	Do you wear glasses or contacts or pro	eyes or tective e	vision?		.] [
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.)?	25.	Have you ever sprained/strained, dislo	cated, fra	ctured, broken or had repeat	ed swel	ling or	other				
Forearm Shin/calf Back Wrist Ankle Hip Hand 26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.)?] 🗆
26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.)?		E C1: / 1C D		Wrist Ankle	r F	Thee Tin					
28. Are you Diabetic?	26.	Have you ever had other medical prob	ems (inf	ectious mononucleosis, diabe	etes, etc	:.)?] 🗆
29. Are you Asthmatic?											
30. Do you have any allergies (medicine, bees or other stinging insects)??	28. 29.	Are you Asthmatic?] [
31. When was your first menstrual period?	30.	Do you have any allergies (medicine, h	ees or o	ther stinging insects)??							j _
31. When was your first menstrual period?		List all allergies:									
What was the longest time between your periods last year?	31.										_
What was the longest time between your periods last year?		When was your last menstrual period?									-
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:		What was the longest time between yo	ur period	ls last year?							-
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:	32.										
Student Signature: Date:	I h-										
			-	_			_		-		

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

		1 ms joi	rm to be sent to the sci	hool (do not send to AS	(AA)	
Student Last N	ame	Stu	dent First Name	MI	Date of birtl	h Grade
					/	<u>/</u>
Height		Weight	•	Blood Pressure	Puls	e
Vision — Right	Eye	Vision	— Left Eye	Vision Corr	ected? Pupi	ls
20/		20/		□ Yes	□ No	
		NORMAL	ABNOR	RMAL FINDINGS		INITIALS
Cardiopulmona	ıry					
_						
Heart						
Lungs						
Skin						
Abdominal						
Genitalia						
Musculoskeleta	ıl					
Neck						
Should	der					
Elbow	,					
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Other						
Clearance:	□ Cle		ted evaluation/rehab	oilitations for (Specifi	ic Sports):	
		cleared for: \Box		` I	act \square Strenuous	
			Moderately Strenuc			
	ъ		·			
	Due	e to:				
Name of M.D.,	, P.A. or	ANP (circle wh	ich) Signatur	'e		Date
						1
Address					Phone	

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