To student athletes and their parents/caregivers:

Before you can play a sport the TSSAA (Tennessee Secondary School Athletic Association) says you must get a sport's physical. This is also called a PPE (Preparticipation Physical Evaluation). The PPE promotes the health and well-being of athletes as they train and compete. It also helps keep athletes safe as they play sports. It is NOT meant to stop them from playing.

Where can you go to get a PPE? In the newest PPE guidebook, the groups below say your doctor's office or the place where you get your medical care is where you can go to get it done:

- the American Academy of Pediatrics,
- the American Academy of Family Physicians,
- the American College of Sports Medicine,
- the American Medical Society for Sports Medicine,
- the American Orthopedic Society for Sports Medicine,
- and the American Osteopathic Academy of Sports Medicine.
- It's also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations.

There are other places you can get a PPE, but **we recommend athletes get a PPE during their Well Visit at their doctor's office or School Based Health Center.** This ensures exams cover everything important about your overall health and well-being. It also limits absences from school and sports.

We encourage you to work the PPE into the routine health care you get at your doctor's office or the place where you get your medical care. If you're enrolled in TennCare your well visits are free.

Sincerely,

Tennessee Secondary School Athletic Association
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Division of TennCare

Do you have TennCare and need to know who your doctor is? You can call your MCO at:

Amerigroup: 1-800-600-4441
BlueCare: 1-800-468-9698
UnitedHealthcare: 1-800-690-1606
TennCare*Select*: 1-800-263-5479

## PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in the heat? | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | | |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

**Explain "Yes" answers here.**

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

## PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

### *PHYSICIAN REMINDERS*

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | | |
| Neurological | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back | | |
| Shoulder and arm | | |
| Elbow and forearm | | |
| Wrist, hand, and fingers | | |
| Hip and thigh | | |
| Knee | | |
| Leg and ankle | | |
| Foot and toes | | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

# CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

**Athlete Information**

Last Name_____ First Name _____ MI _____

Sex: [ ] Male [ ] Female Grade _____ Age _____ DOB ____/____/_____

Allergies _____

Medications_____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

**Emergency Contact Information**

Home Address _____(City)_____(Zip)_____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

## Legal/Parent Consent

I/We hereby give consent for (**athlete's name**) _____ to represent (**name of school**) _____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

_____ _____ _____

**Signature of Athlete** **Signature of Parent/Guardian** **Date**

# CONSENTIMIENTO A PARTICIPAR EN ACTIVIDADES ATLETICAS Y RECIBIR CUIDADO MEDICO SI FUERA NECESASRIO

(Este Consentimiento debe ser completado por el Estudiante-Atleta y sus padres o guardianes.)

**Información del Estudiante-Atleta**

Apellido _____ Nombre _____ SN _____

Sexo: [ ] Varón [ ] Hembra Grado_____ Edad_____ Fecha de Nacimiento_____/_____/_____

Alergias _____

Medicaciones _____

Seguro Médico _____ Número de la Póliza _____

Número del Grupo _____ Teléfono del Seguro _____

**Información del Contacto en Caso de Emergencia**

Dirección de Casa _____ (Ciudad) _____

(Código Postal) _____

Teléfono de Casa _____ Celular de la Madre o Guardian _____

Celular del Padre o Guardian _____

Nombre de la Madre o Guardian _____ Teléfono del Trabajo _____

Nombre del Padre o Guardian _____ Teléfono del Trabajo _____

Otra Persona Contacto _____

Número de Teléfono _____ Relación _____

## Consentimiento Legal de los Padres o Guardianes

Yo/Nosotros damos nuestro consentimiento para que (nombre del Estudiante-Atleta)_____ pueda representar (nombre de la escuela)_____ en deportes y que yo/nosotros entendemos que esa actividad lleva la posibilidad de sufrir lesiones. Yo/Nosotros sabemos que aún con el mejor entrenamiento, los mejores artículos deportivos, y la observación estricta de las reglas, es posible sufrir lesiones. **En algunas ocasiones, estas lesiones son severas y pueden resueltar en incapacidad, parálisis, y hasta la muerte. Yo/Nosotros damos permiso a la escuela y a TSSAA, sus médicos, entrenadores atléticos, y/o técnicos médicos de emergencias a dar ayuda, tratamiento, cuidado médico o quirúrgico considerados necesarios para la salud y bienestar del Estudiante-Atleta nombrado arriba durante o como resultado de su participación en los deportes.** Al firmar este consentimiento, el Estudiante-Atleta nombrado arriba y sus padres/guardianes consienten a que los profesionales de la salud conduzcan un chequeo, examinación, y pruebas del Estudiante-Atleta durante la examinación pre-participacipatoria y a obtener la historia médica. Entendemos que los profesionales de la salud que conduzcan estas pruebas y evaluaciones van a anotar los resultados y observaciones en los formularios y records que acompañan este documento. Como padre o guardian , **yo/nosotros entendemos que somos totalmente responsables por cualquier asunto legal que pueda resultar de las acciones personales del Estudiante-Atleta nombrado arriba.**

Firma del Estudiante-Atleta Firma del Padre/Guardian Fecha

# Insurance Coverage Statement

- I understand that the athletic insurance carried by the school system is a secondary coverage policy meaning it pays only after the parents' primary coverage pays.

- I understand that the responsibility to file the proper forms for payment is the parent's responsibility.

- I understand that medical expenses **ARE MY RESPONSIBILITY** in connection with my child playing voluntary sports.

- I understand that I accept financial responsibility for any injury not covered by my hospitalization insurance or KCS sport accident insurance.

_____ _____

*Parent/Legal Guardian Signature* *Date*

# CONCUSSION

## INFORMATION AND SIGNATURE FORM
## FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS
**(Adapted from CDC "Heads Up Concussion in Youth Sports")**

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

**Read and keep this page.**
**Sign and return the signature page.**

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

### WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

| SIGNS OBSERVED BY COACHING STAFF | SYMPTOMS REPORTED BY ATHLETES |
|---|---|
| Appears dazed or stunned | Headache or "pressure" in head |
| Is confused about assignment or position | Nausea or vomiting |
| Forgets an instruction | Balance problems or dizziness |
| Is unsure of game, score or opponent | Double or blurry vision |
| Moves clumsily | Sensitivity to light |
| Answers questions slowly | Sensitivity to noise |
| Loses consciousness, even briefly | Feeling sluggish, hazy, foggy or groggy |
| Shows mood, behavior or personality changes | Concentration or memory problems |
| Can't recall events *prior* to hit or fall | Confusion |
| Can't recall events *after* hit or fall | Just not "feeling right" or "feeling down" |

**Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training*

## CONCUSSION 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 after a bump, blow or jolt to the head or body if 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*)

## WHY SHOULD AN ATHLETE REPORT HIS OR HER 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 brains. *They can even be fatal.*

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.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

## Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

| Student-Athlete initials | | Parent/Legal Guardian initials |
|---|---|---|
| | A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available. | |
| | A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury. | |
| | I will tell my parents, my coach and/or a medical professional about my injuries and illnesses. | N/A |
| | I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms. | N/A |
| | I will/my child will need written permission from a *health care provider** to return to play or practice after a concussion. | |
| | Most concussions take days or weeks to get better. A more serious concussion can last for months or longer. | |
| | After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse. | |
| | After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away. | |
| | Sometimes repeat concussion can cause serious and long-lasting problems and even death. | |
| | I have read the concussion symptoms on the Concussion Information Sheet. | |

* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal guardian Date

**Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form**

**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 doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

**How common is sudden cardiac arrest in the United States?**
SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

**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 are the risks of practicing or playing after experiencing these symptoms?**
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

**Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act**
The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  (i) Unexplained shortness of breath;
  (ii) Chest pains;
  (iii) Dizziness
  (iv) Racing heart rate; or
  (v) Extreme fatigue; and

- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

*I have reviewed and understand the symptoms and warning signs of SCA.*

---

Signature of Student-Athlete Print Student-Athlete's Name Date

_____ _____ _____

Signature of Parent/Guardian Print Parent/Guardian's Name Date

## Sports Medicine Outreach

## OTC and Prescription Medication Policy

These policies apply only to the hours after school when a student-athlete is in need of OTC or prescription medications and request these of the Certified Athletic Trainer (ATC). The Knox County Board of Education Medication Policy applies during school hours.

**Prescription medications may only be administered by the ATC with verbal or written permission from a parent or legal guardian and written orders from the healthcare provider who had legal right to prescribe the medication must be on file with ATC.** Prescription medications include but are not limited to inhalers and epi-pens. The written order **must include** the name of the medication, dosage, frequency or time interval, route or method of administration, time to be administered, possible side effects and method of storage.

All medications must be in appropriate containers that are properly labeled. All medications kept in the athletic training room will be kept under lock and key and any medications kept in the AT's medical kit will be placed in an unlabeled inconspicuous container. Each medication will be labeled with the athletes name and placed in an individual container.

---

## Permission Form

I, _____, give permission to **Cindi Juarez-Logan**, athletic trainer for Hardin Valley Academy, to store and administer my child's medication as needed for its intended/prescribed purpose.

Please check one option. This medication is € prescribed by a physician € OTC/non-prescription

Name of Student Athlete: _____

Name of Medication:_____

If prescription, please indicate the following per the prescription on the bottle/container. If **OTC**, skip.
Dosage: _____ Frequency: _____ Time/Use: _____

Route (circle one): Orally | Injection | Nasally | Sublingual | Inhalation | Ocular | Topical | Other

Possible side effects:_____

Parent/Guardian Signature: _____ Date: _____