Omaha Public Schools
Pre-Season Physical Screening Exams

Omaha Public Schools (OPS) is pleased to offer pre-season physical screening examinations (physicals) to its student athletes entering grades 8-12. The physicals are conducted in early May, prior to the start of the school year and fall sports season. The physicals are offered at a low cost, so that they are affordable to all students participating in OPS sports. Please read the following information and complete the **OPS Sports Physical Form**, also known as the **OPS School & Sports Qualifying Screening Evaluation**, before your student comes to a physical exam. This form may be used any time of the year.

- **Limitations to Physical Screening Exam**: The physical is strictly a screening examination and is NOT a substitute for routine, comprehensive health care by the student's primary care physician. Parents/guardians should consider the benefits of having their student-athlete cleared for sports by their own personal physician, especially if the student has a known chronic health condition such as a heart condition, asthma, uncontrolled high blood pressure, diabetes, or repeated concussions.

- **OPS Sports Physical Form**: Parents/guardians must complete and sign all portions of the OPS sports physical forms except the “Examination” section. The OPS Sports Physical Form is posted on the OPS web site at [www.ops.org](http://www.ops.org) under the “Parents” link, Physical Exams. The form must be filled out accurately and thoroughly. Parents/guardians should be sure to list all of the student’s health issues in the “History” section of the form. Your signature on the form indicates consent for a minor (under the age of 18) to receive the physical and is required for the physical to be performed.

- **Day of the Physical**: Parents/guardians are welcome to accompany their student to the physical. Students should bring their completed and signed OPS Sports Physical Form and dress appropriately for the physical. Boys should wear gym shorts and T-shirts. Girls should wear gym shorts, T-shirts, and sports bra, if possible. Students in “street clothes” will be asked to change into gym clothes for the physical.

- **Questions**: If you have any questions or concerns, please contact 402-557-2407 or your school athletic office. You are also welcome and encouraged to accompany your student to the physical and address any concerns you have to the examining team.

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**THE ABOVE INFORMATION IS USED FOR OPS FALL PRE-SEASON SCREENING EXAMS ONLY**

**OMAHA PUBLIC SCHOOLS – Student Form**

**ATHLETIC INSURANCE COVERAGE**

Your school, acting for members of the athletic squad, makes available an Athletic Injury Benefit Plan approved by the Omaha Board of Education. The total premium is paid by the student or parent. The purpose of such coverage is to assist in the cost of treatment of accidental injury. Payments are in addition to any payments by another company for the same injury.

SQUAD MEMBERS MUST HAVE INSURANCE COVERAGE TO PARTICIPATE.

Check the statements that apply:

- _____ I shall participate in the Athletic Benefit Injury Plan. Information brochures, if not attached, are available from the school office upon request.
- _____ I have accident injury coverage with the ___________________________________________ Insurance Company.

POLICY NO. __________________________ Signature of Parent/Guardian _________________________________________

Date ________________________________ Address __________________________________________________________

Note: This form is to be filled out completely and filed in the office of the school before student is allowed to practice and/or compete.
Preparticipation Physical Evaluation

Date of Exam ____________________________

Name __________________________________

Sex ______ Age ______ Date of Birth ______

Grade ______ School _____________________

Sport(s) _______________________________

Address _________________________________________

Phone __________________________

Personal physician __________________________

In case of emergency, contact

Name ____________________________

Relationship _____________

Phone (H) ____________ (W) ____________

Name in case of emergency _________________________________________________________

Personal physician _______________________________________________________________


In this section, circle “YES” answers to indicate conditions that may limit your activity or participation in school sports activities.

1. Has a doctor ever denied or restricted your participation in sports for any reason? __________
2. Do you have an ongoing medical condition? 
   (like diabetes or asthma) __________
3. Are you currently taking any prescriptions or nonprescription (over-the-counter) medicines or pills? __________
4. Do you have allergies to medicines, pollens, foods, or stinging insects? __________
5. Have you ever passed out or nearly passed out DURING exercise? __________
6. Have you ever passed out or nearly passed out AFTER exercise? __________
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? __________
8. Does your heart race or skip beats during exercise? __________
9. Has a doctor ever told you that you have (check all that apply): 
   - High blood pressure __________
   - Heart murmur __________
   - High cholesterol __________
   - Heart infection __________
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) __________
11. Has anyone in your family died for no apparent reason? __________
12. Does anyone in your family have a heart problem? __________
13. Has anyone in your family been told they have heart problems? __________
14. Does anyone in your family have Marfan syndrome? __________
15. Have you ever spent the night in a hospital? __________
16. Have you ever had surgery? __________
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle area below. __________
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below. __________
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below. __________
20. Have you ever had a stress fracture? __________
21. Have you been told that you have or you have had an x-ray for atlantoaxial (neck) instability? __________
22. Do you regularly use a brace or assistive device? __________
23. Has a doctor ever told you that you have asthma or allergies? __________
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? __________
25. Is there anyone in your family who has asthma? __________
26. Have you ever used an inhaler or taken asthma medicine? __________
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? __________
28. Have you had infectious mononucleosus (mono) within the last month? __________
29. Do you have any rashes, pressure sores, or other skin problems? __________
30. Have you had a herpes skin infection? __________
31. Have you ever had a head injury or concussion? __________
32. Have you been hit in the head and been confused or lost your memory? __________
33. Have you ever had a seizure? __________
34. Do you have headaches with exercise? __________
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? __________
36. Have you ever been unable to move your arms or legs after being hit or falling? __________
37. When exercising in the heat, do you have severe muscle cramps or become ill? __________
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? __________
39. Have you had any problems with your eyes or vision? __________
40. Do you wear glasses or contact lenses? __________
41. Do you wear protective eyewear, such as goggles or a face shield? __________
42. Are you happy with your weight? __________
43. Are you trying to gain or lose weight? __________
44. Has anyone recommended that you change your weight or eating habits? __________
45. Do you limit or carefully control what you eat? __________
46. Do you have any concerns that you would like to discuss with a doctor? __________

FEMALES ONLY

47. Have you ever had a menstrual period? __________
48. How old were you when you had your first menstrual period? ______
49. How many periods have you had in the last year? ______

Explain “YES” answers here: ________________________________________________________________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete __________________________
Signature of parent/guardian __________________________ Date __________

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for purposes of participation in athletics and activities.

Parent or Legal guardian signature __________________________ Date __________
<table>
<thead>
<tr>
<th>Cardiovascular Health</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever told you that you have any heart problems? If so, check all</td>
<td></td>
<td></td>
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<tr>
<td>that apply: High blood pressure   A heart murmur   High cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A heart infection   Kawasaki Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>2. Do you get light headed or feel more short of breath than expected during</td>
<td></td>
<td></td>
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<tr>
<td>exercise?</td>
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<tr>
<td>3. Do you get more tired or short of breath more quickly than your friends during</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise?</td>
<td></td>
<td></td>
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<tr>
<td>4. Has any family member or relative died of heart problems or had an unexpected or</td>
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<td></td>
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<tr>
<td>unexplained death before age 50 (including drowning, unexplained car accident, or</td>
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<td></td>
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<tr>
<td>Sudden Infant Death Syndrome)?</td>
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<tr>
<td>5. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome,</td>
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<td></td>
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<tr>
<td>arrhythmogenic right ventricular cardiomyopathy, Long QT Syndrome, Short QT Syndrome,</td>
<td></td>
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<tr>
<td>Brugada Syndrome, a catecholaminergic polymorphic ventricular tachycardia?</td>
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<tr>
<td>6. Does anyone in your family have a heart problem, pace maker, or implanted</td>
<td></td>
<td></td>
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<tr>
<td>defibrillator?</td>
<td></td>
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<tr>
<td>7. Has anyone in your family had unexplained fainting, unexplained seizures, or near</td>
<td></td>
<td></td>
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<tr>
<td>drowning?</td>
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</table>

<table>
<thead>
<tr>
<th>Bone and Joint Health</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>8. Do you have any bone, muscle, or joint injury that bothers you?</td>
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<tr>
<td>9. Do any of your joints become painful, swollen, feel warm, or look red?</td>
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<tr>
<td>10. Do you have any history of juvenile arthritis or connective tissue disease?</td>
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<table>
<thead>
<tr>
<th>General Medical</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>11. Have you had a herpes or MRSA skin infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have you had any eye injuries?</td>
<td></td>
<td></td>
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</tbody>
</table>
**Preparticipation Physical Evaluation**

Name _______________________________ Date of birth ____________________

Height _______ Weight _______ Pulse _______ BP _____/____ ( _____/____ , _____/____ )

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<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat/pupils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murmurs</td>
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<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
<td></td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
<td></td>
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<tr>
<td>Wrist/hand/fingers</td>
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<td></td>
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<tr>
<td>Hip/thigh</td>
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<td></td>
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<tr>
<td>Knee</td>
<td></td>
<td></td>
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<tr>
<td>Leg/ankle</td>
<td></td>
<td></td>
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<tr>
<td>Foot/toes</td>
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</tr>
</tbody>
</table>

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**Preparticipation Physical Evaluation**

Name _______________________________ Sex _____ Age _____ Date of birth ____________

☐ Cleared without restriction ☐ Cleared, with recommendations for further evaluation or treatment for: ____________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

☐ Not cleared for ☐ All sports ☐ Certain sports: ____________ Reason: ____________

Recommendations:

__________________________________________________________________________

__________________________________________________________________________

Name of physician (print/type) _______________________________ Date ____________

Address _______________________________ Phone _______________________________

Signature of physician _______________________________, MD or DO
NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)/Omaha Public Schools (OPS)
Student and Parent Consent Acknowledgement and Release Form

School Year - 20____ - 20____ Member School: ___________________________

Name of Student: _________________________________________________________

Date of Birth: __________________ Place of Birth: _____________________________

The undersigned(s) are the student and the parent(s), or guardian(s) in charge of the above named student and are collectively referred to as “Parent”.

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;

(2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body’s bones, joints, ligaments, tendons, or muscles to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) even the best coaching, the use of the best protective equipment and strict observance of the rules. Injuries are still a possibility;

(3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and;

(4) Consent and agree to (a) the disclosure by the Member school at which the Student is enrolled in the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student’s name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major field of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student’s participation in NSAA sponsored activities; and (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such photographs or recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

(5) Consent and agree for the above named student to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I/We authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary in the course of such athletic activities or travel.

(6) WITH FULL UNDERSTANDING OF THE RISKS INVOLVED, RELEASE, INDEMNIFY, AND HOLD HARMLESS THE OMAHA PUBLIC SCHOOLS AND ITS OFFICERS, AGENTS, REPRESENTATIVES, AND EMPLOYEES (COLLECTIVELY THE “RELEASEES”) FROM ANY AND ALL LOSSES, CLAIMS, DEMANDS, ACTIONS AND CAUSES OF ACTION, OBLIGATION, DAMAGES, AND COSTS OR EXPENSES OF ANY NATURE (INCLUDING ATTORNEY’S FEES) THAT THE STUDENT AND OR PARENTAL/LEGAL GUARDIAN INCUR OR SUSTAIN TO PERSON, PROPERTY OR BOTH, WHICH ARISE OUT OF, RESULT FROM, OCCUR DURING OR ARE OTHERWISE CONNECTED WITH THE STUDENT’S PARTICIPATION IN NSAA OR OMAHA PUBLIC SCHOOLS ACTIVITIES OR TRAVEL RELATED TO SUCH ACTIVITIES IF DUE TO ACCIDENT, MISHAP, OR ORDINARY NEGLIGENCE OF THE RELEASEES.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in athletic activities and the release.

WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.

Dated this ______ day of __________________, ________.

Name of Student [Print Name]                      Student Signature

(I am) (We are) the [circle the appropriate choice] (Parent) (Guardian). (I) (We) acknowledge that (I) (We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I) (We) hereby give (my) (our) permission for __________________________ [insert student name] to practice and compete for the above named high school/middle school in activities approved by the NSAA, except those crossed out below:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseball</td>
<td>Golf</td>
<td>Tennis</td>
<td>Debate</td>
<td>Speech</td>
</tr>
<tr>
<td>Basketball</td>
<td>Swimming</td>
<td>Track</td>
<td>Journalism</td>
<td></td>
</tr>
<tr>
<td>Cross Country</td>
<td>Soccer</td>
<td>Volleyball</td>
<td>Music</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>Softball</td>
<td>Wrestling</td>
<td>Play Production</td>
<td></td>
</tr>
</tbody>
</table>

Dated the ______ day of __________________, ________

Parent/Guardian [Print Name]                      Parent/Guardian Signature
OMAHA PUBLIC SCHOOLS HEAD INJURY/CONCUSSION
ACKNOWLEDGEMENT FORM

I understand there is a possibility that participation in any sport may result in a head injury and/or concussion. Furthermore, I have been provided with the Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet and understand the importance of reporting a head injury and/or concussion to parents, coaches and athletic training staff.

After reading the Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet, I am aware of the following information:

- A concussion is a brain injury, which I am responsible for reporting;

- A concussion can affect one’s ability to perform everyday activities, affect reaction time, balance, sleep quality, and classroom performance;

- A student athlete will not be allowed to return to a game or practice until cleared by a physician or the OPS Athletic Training Staff;

- Following a concussion, the brain needs time to heal. There is an increased likelihood for a repeat concussion if the individual returns to play before symptoms have resolved;

- In certain instances, repeat concussion can cause permanent brain damage, even death; and

- At any point following a suspected concussion, any of the following individuals reserves the right to voice concern for the safety of a student athlete and prohibit him or her from returning to play: physician, coach, student athlete, athletic trainer, parent.

By signing below, I understand the importance of the statements above and have asked any, and all questions regarding the above statements. I further understand that I will not be allowed to participate in OPS athletics until this form is signed by a parent/guardian.

I hereby attest that I have read, fully understand, and will abide by the above statements.

Student Athlete Name ____________________________________________________________

Sport(s)____________________________________________________________________________________________________

Student Athlete Signature ________________________________________________________Date __________________________

Parent/Guardian Signature (required) _______________________________________________Date __________________________
Did You Know?
According to the Center for Disease Control and other publications:

- Each year 300,000 athletes suffer sports-related concussions.
- The national estimate for concussions in high school athletes is 136,000.
- In ages 15-24, sports are the 2nd leading cause of traumatic brain injury.
- Most studies done on concussions focus on the “mature” brain and thus, we cannot ignore the fact that the young brain is still developing and the effects of concussions are not fully understood.
- High school athletes who sustain a concussion demonstrate prolonged memory dysfunction compared with college athletes.
- A concussion is: “getting your bell rung,” and “getting dinged.”
- Failure to recognize and properly manage a concussion can lead to a catastrophic injury known as “second impact syndrome.”
- Second impact syndrome can be catastrophic, even fatal.
- Second impact syndrome is preventable — if concussions are recognized and properly managed.
- On April 18, 2011, LB 260 – “The Concussion Awareness Act” was signed into law with the intent to protect the youth participating in athletics across the state from the dangers of concussions that are often unrecognized, undiagnosed, and/or mismanaged.

Sources:

WHAT DOES A CONCUSSION LOOK LIKE?

<table>
<thead>
<tr>
<th>SIGNS:</th>
<th>SYMPTOMS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appears dazed or stunned</td>
<td>1. Headache or “pressure” in the head</td>
</tr>
<tr>
<td>2. Is confused about an assignment</td>
<td>2. Nausea</td>
</tr>
<tr>
<td>3. Forgets plays</td>
<td>3. Balance problems or dizziness</td>
</tr>
<tr>
<td>4. Moves clumsily or displays problems with balance and coordination</td>
<td>4. Double or fuzzy vision</td>
</tr>
<tr>
<td>5. Loses consciousness (even briefly)</td>
<td>5. Sensitivity to light or noise</td>
</tr>
<tr>
<td>6. Shows behavioral of personality changes</td>
<td>6. Feeling slowed down, foggy, or groggy</td>
</tr>
<tr>
<td>7. Does not “feel right”</td>
<td></td>
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</tbody>
</table>
Guidelines For Concussion Management:
The Goals and Outcomes of the OPS Sports Medicine Advisory Committee on Concussion Management

**GOAL**
To prevent increasing the severity of the injury.

**Guideline**
All concussions will be assessed using guidelines established by the 2008 International Conference on Concussion in Sport.

For complete details, please see your school’s Certified Athletic Trainer.

**GOAL**
To prevent re-injury through proper management.

**Guideline**
1. A student athlete will be removed from a practice or game when he or she is reasonably suspected of sustaining a concussion or head injury;
2. The student athlete will be evaluated by qualified medical personnel;
3. The student athlete will not be allowed to return to play until he or she is asymptomatic and exhibit no neuropsychological or neuropsychological deficits during follow-up ImPact Testing; and
4. The student athlete will not be allowed to return to practice or competition until he or she has been cleared by a physician or OPS Certified Athletic Trainer and has completed a medically supervised stepwise return to play progression.

For complete details, please see your school’s Certified Athletic Trainer.

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_BRAIN INJURIES (CONCUSSIONS) SHOULD NOT BE TAKEN LIGHTLY. ONLY THROUGH IMMEDIATE AND EARLY RECOGNITION AND PROPER MANAGEMENT, CAN WE PREVENT A POTENTIALLY LIFE ALTERING EVENT._

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**If your son or daughter has sustained a concussion:**
1. Seek medical attention (physician, ER, athletic trainer)
2. Keep them out of play
3. Tell all athletic trainers and coaches about any previous or current concussions

Source: Center for Disease Control (www.cdc.gov)

Resources for information on concussions and this policy may be found:
1. Center for Disease Control [www.cdc.gov](http://www.cdc.gov)
2. Omaha Public Schools website [www.ops.org](http://www.ops.org)
4. National Federation of State High Schools Association [www.nfhs.org](http://www.nfhs.org)

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~What to Do if You Suspect Your Child Has Suffered a Concussion~

A student athlete should be taken to the emergency (ER) department if any of the following signs or symptoms are present.

- Headaches that worsen
- Seizures
- Looks very drowsy and cannot be awakened
- Repeated vomiting
- Slurred speech
- Cannot recognize people or places
- Increasing confusion or irritability
- Weakness or numbness in arms or legs
- Neck pain
- Unusual behavior change
- Any loss of consciousness
- Any symptoms that worsen or do not improve over time
- Increase in the number of symptoms
- Symptoms which begin to interfere with the student’s daily activities