OMAHA PUBLIC SCHOOLS
7TH GRADE PHYSICAL SCREENING EXAM

The Nebraska State School Law, in part, requires a physical exam for entrance into seventh grade. A complete dental check-up is strongly encouraged at this time also.

If you do not wish to provide evidence of a physical exam, a signed statement waiving this requirement must be submitted to the school by November 1 (or 60 days after enrollment). Please note, if your child will be participating in competitive athletics, a physical examination by a licensed health care provider is required and signing a waiver does not satisfy this requirement.

Physical Education Restrictions/Exemptions: Middle or high school students who have restrictions for participation in PE must have a health care provider's order on file, delineating what the restrictions are. Students who cannot participate because of health related concerns must have a health care provider's note on file exempting them from the class.

The following forms are necessary for a 7th grade physical: The Health Exam Card and Preparticipation History Form are necessary for a school physical only. The Athletic Insurance Coverage, NSAA/OPS Student/Parent Consent, Head Injury/Concussion Acknowledgement, Concussion Information and Fact Sheet, and Guidelines for Concussion Management are necessary for participation in after-school sports.

Athletic physicals are necessary for anyone participating in an after-school sport. Having the Preparticipation History Form filled out in advance by the student and parent will not cause a delay should your student choose to participate in a sport at a later date.

History Form to be completed/signed by student **before** 7th grade physical with review and sign off by parent for possible future athletic participation. Health care provider completes Health Exam Card and reviews History Form. For participation in after-school sports, Insurance and Consent Form completed by student and parent. The Head Injury/Concussion Acknowledgement is to be reviewed and signed by student and parent.

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**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.
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 [ ]
   - A heart murmur [ ]
   - High cholesterol [ ]
   - A 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 any family member or relative died of heart problems or of sudden death before age 50? [ ] [ ]
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 affected 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 have you 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: ___________________________ Date: ___________________________
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: ___________________________
**OMAHA PUBLIC SCHOOLS**  
**HEALTH EXAMINATION CARD**  
Side 1 of 2

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Birthday</th>
<th>Gender: M  F</th>
<th>Address</th>
<th>Phone</th>
<th>School</th>
<th>Grade</th>
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</table>

<table>
<thead>
<tr>
<th>Parent or Guardian’s Name</th>
<th>Name of Health Care Provider</th>
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### IMMUNIZATIONS
(Obtain a copy of the immunization record if possible)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Month/Day/Year</th>
<th>Immunization</th>
<th>Month/Day/Year</th>
<th>Immunization</th>
<th>Month/Day/Year</th>
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<tr>
<td>DTaP 1</td>
<td>/ /</td>
<td>Polio 1</td>
<td>/ /</td>
<td>HEP B</td>
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<td>Td 1</td>
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<td>MMR 1</td>
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<tr>
<td>HIB 1</td>
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<td>/ /</td>
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</tr>
<tr>
<td>Tdap 1</td>
<td>/ /</td>
<td>Prevnar 1</td>
<td>/ /</td>
<td></td>
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<tr>
<td>2</td>
<td>/ /</td>
<td>2</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date parent reported disease</td>
<td>3 / /</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4 / /</td>
<td>Influenza</td>
<td>/ /</td>
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</table>

| VZV 1 | / / | Prevnar 1 | / / |
| 2 / / |

| HPV 1 | / / | Meningococcal | / / |
| 2 / / |

**HEALTH HISTORY**

- Fainting
- Head Injury
- Asthma
- Seizure
- Surgery
- Allergies
- Other, describe
- Family history of sudden death prior to age 50

**PHYSICAL EXAMINATION**

- General Appearance
- Height
- Weight
- BMI
- Lab: HCT or HGB
- Lead level drawn
- Yes  No
- BP
- Skeletal Development
- Posture
- Scoliosis
- Hair/Skin
- Lymph
- Head/Neck
- Ears
- Nose/Sinus
- Throat
- Mouth
- Dental
- Speech
- Heart
- Rhythm
- Rate
- Chest/Lungs

(over)
Abdomen ______________________________________________ Back _____________
Extremities ________________________________________________
Neurological Exam _______________________________________________________________________________________
Mental development assessment ____________________________________________________________________________
Medical diagnosis _________________________________________________________________________________________
Is this child subject to any condition limiting classroom or physical activities? ___ No        ___ Yes
   If “Yes”, describe ____________________________________________________________
Is this child taking any medication? ___No   ___Yes   if “Yes”, list medications _________________________________
List concerns/remarks ______________________________________________________________________________________

**HEARING SCREENING:**

<table>
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<tr>
<th>Audio Test</th>
<th>500Hz</th>
<th>1000Hz</th>
<th>2000Hz</th>
<th>4000Hz</th>
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<tr>
<td>Right Ear------dB</td>
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<td></td>
<td></td>
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<tr>
<td>Left Ear-------dB</td>
<td></td>
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**VISION EXAM** required for Kindergarten and students transferring from outside of NE

<table>
<thead>
<tr>
<th>Tests</th>
<th>Pass</th>
<th>Fail</th>
<th>Recommend Further Examination (See Comments Below)</th>
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<tbody>
<tr>
<td>Amblyopia</td>
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</tr>
<tr>
<td>Strabismus</td>
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<td></td>
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<tr>
<td>Internal Eye Health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>External Eye Health</td>
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<td></td>
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<tr>
<td>Visual Acuity</td>
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</tr>
</tbody>
</table>

Comment/Recommendations/Restrictions
__________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Date of PE       Signature of Licensed Health Care Provider    Office Phone #
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 he or she 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 __________________________
Guidelines For Concussion Management:
The Goals and Outcomes of the OPS Sports Medicine Advisory Committee on Concussion Management

<table>
<thead>
<tr>
<th>GOAL</th>
<th>GOAL</th>
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</thead>
<tbody>
<tr>
<td>To prevent increasing the severity of the injury.</td>
<td>To prevent re-injury through proper management.</td>
</tr>
</tbody>
</table>

**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.

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.

**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 neuropsychometric 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.

**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
2. Omaha Public Schools website
   www.ops.org
3. National Athletic Trainers Association
   www.nata.org
4. National Federation of State High Schools Association
   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
Omaha Public Schools Sports Medicine Advisory Committee
Parent and Student Athlete Concussion Information
and Fact Sheet

In the fall of 2008, the Certified Athletic Trainers and Physicians working with OPS began utilizing new guidelines to evaluate, assess, and manage concussions incurred by OPS student athletes. Since then the guidelines have been reviewed and updated annually to reflect emerging best practices in the recognition and management of concussions in youth sports.

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:


According to a study by McCrea published in 2004, The top reasons for athletes not reporting concussions were:

1. Didn’t think the concussion was serious.
2. Didn’t want to leave the game.
3. Didn’t realize a concussion was sustained.
4. Didn’t want to let down their teammates.

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 or personality changes</td>
<td>6. Feeling slowed down, foggy, or groggy</td>
</tr>
<tr>
<td>7. Does not “feel right”</td>
<td></td>
</tr>
</tbody>
</table>