# SDHSAA HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

**Name:** _____ **Date of Birth:** _____

**Date of Exam:** _____ **Sports:** _____

| | |
|---|---|
| List all past and current medical conditions: | |
| Have you ever had surgery? If Yes, list all procedures: | |
| List all prescriptions, over-the-counter meds or supplements you currently take: | |
| Do you have any allergies? If Yes, Please list them here: | |

**Over the last two weeks, how often have you been bothered by 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 in pleasure or doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| *A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes* | | | | |

**ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR"**
**& EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Do you have any concerns you'd 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 illnesses? | | |
| **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? (Example: electrocardiography or echocardiography) | | |
| 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 35 years of age (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 (CVPT)? | | |
| 13. Has anyone in your family had a pacemaker or 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 a game? | | |

| BONE AND JOINT QUESTIONS, CONTINUED: | Yes | No |
|---|---|---|
| 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, 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 recurring skin rashes or rashes that come and go, including herpes or 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, tingling or 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? | | |
| 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? | | |
| 29. Have you ever had COVID-19? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 30. Have you ever had a menstrual period? | | |
| 31. How old were you when you had your first period? | | |
| 32. When was your most recent period? | | |
| 33. How many periods have you had in the past 12 months? | | |

**CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:**

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

# SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

**Athlete Name:** _____ **Date of Birth:** _____

**Date of Exam:** _____ **Annual/Biennial/Triennial:** _____

***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, vaping, chewing tobacco, snuff or dip?
   - Over the past 30 days, have you used 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 seatbelt or helmet?
2. **Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)**

| **EXAMINATION** | | |
|---|---|---|
| Height: | Weight: | BP: |
| Pulse: | Vision: R 20/ L 20/ | Corrected?: |

| **MEDICAL** | **Normal** | **Abnormal Findings** |
|---|---|---|
| **Appearance** | | |
| **Head/Mouth** | | |
| **Eyes, ears, nose and throat -** Pupils equal & Hearing | | |
| **Lymph Nodes** | | |
| **Heart* -**Heart sounds, murmurs, pulse, rhythm, auscultation | | |
| **Lungs** | | |
| **Abdomen -** Liver/Spleen, masses | | |
| **Skin -** HSV, Lesions, Staph, MRSA, etc. | | |
| **Neurological** | | |
| **MUSCULOSKELETAL** | **Normal** | **Abnormal Findings** |
| **Neck** | | |
| **Back** | | |
| **Shoulder & Arm** | | |
| **Elbow & Forearm** | | |
| **Wrist, Hand and Fingers** | | |
| **Hip & Thigh** | | |
| **Knee** | | |
| **Leg & Ankle** | | |
| **Foot & Toes** | | |
| **Functional**<br>• Double-leg squat test, single-leg squat test, box drop or step drop test | | |

***** *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination*

**Sports Participation Recommended for (Mark One):**

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____

☐ Medically eligible for certain sports (list here): _____

☐ Not medically eligible pending further evaluation: _____

☐ Not medically eligible for any sports: _____

**Name of Examiner:** _____

**Signature of Examiner:** _____

**Date of Exam:** _____

**Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.**

# *Lead-Deadwood School District*
# *Assumption of Risk / Permission / Acknowledgement Form*
# *In Co-Curricular Activities*

## Risk of Injury

**By the very nature of athletic activity, participants are at risk of physical injury. No matter how careful the athlete and the coach are, no matter how many precautions are taken, the risk cannot be eliminated. It can be reduced but never eliminated. The risk of injury includes minor injuries such as broken bones, dislocations and muscle strains. The risk also includes catastrophic injuries such as permanent paralysis or even death. It is important everyone understands these risks, and that athletes follow all safety directions from their coaches because they are established to reduce the risk of injury.**

I have read the co-curricular activities policies and regulations. I am aware of the co-curricular activity eligibility and pre-participation requirements, basic rules, and regulations and the responsibilities connected with being a participant of a Lead-Deadwood School District extracurricular activity.

I request permission to participate in extracurricular activities and agree to abide by the requirements, rules and regulations set forth in the requirements, rules and regulations.

In consideration of being allowed to participate in any way in the athletic program, and related events and activities, the undersigned:

1. Acknowledge and fully understand that each participant will be engaging in activities which involve risk of injury. The injury could be serious or catastrophic including permanent disability.
2. Assume all the forgoing risks and accept personal responsibility for damages following such injury, permanent disability or death.

_____ _____

Athlete Signature Date

We grant permission for our child to participate in co-curricular activities and agree to assume the parental responsibilities set forth in the co-curricular activity eligibility and pre-participation requirements, basic rules and regulations if our child is participating. If we have not purchased school medical or hospitalization coverage, our child has our further permission to participate without coverage for the reason that our child is covered by our own private or group medical and hospitalization plan **or** we do not wish to provide any medical or hospitalization coverage.

In consideration of being allowed to participate in any way in the athletic program, and related events and activities, the undersigned:

1. Acknowledge and fully understand that each participant will be engaging in activities which involve risk of injury. The injury could be serious or catastrophic including permanent disability.
2. Assume all the forgoing risks and accept personal responsibility for damages following such injury, permanent disability or death.

_____ _____

Parent and / or Legal Guardian Date

# SDHSAA CONSENT FOR PARTICIPATION IN ACTIVITIES

**Student Name:** _____ **Date of Birth:** _____

**School Year: 2024-25 School Year** **Place of Birth:** _____

**Name of High School:** _____

**The parent and student, by signing this form, hereby:**

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that:
   (a) By this Consent Form the SDHSAA has provided notification 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 injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death;
   (d) Even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility; and;
   (e) By signing this form, I/we give our consent for the listed student to compete in SDHSAA approved athletics for the school year as listed on this form. Further, I/we give our permission for our child to participate in organized high school athletics, realizing that such activity involves the potential for injury and harm which exists as an inherent element in all sports.

3. Understand, consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Understand, consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. If I/we do not wish to have any or all such information disclosed, I/we must notify the above-mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.

_____ _____

**Signature of Parent** **Date**

_____ _____

**Signature of Student** **Date**

# *SDHSAA CONSENT FOR MEDICAL TREATMENT FORM*

**Student Name: _____ Date of Birth: _____**

The SDHSAA recommends that all member schools receive consent from all students and parent/guardians prior to activities, to ensure that medical care can be provided to the student during any activity away from home. This form should be kept both on-file at the school, as well as in the possession of a student's coach/sponsor authorizing as below:

**CONSENT FOR MEDICAL TREATMENT (for those children 18 and under at any time during the 2024-25 school year):**

I, _____, am the (circle one) Parent or Legal Guardian, of _____, who participates in activities and/or athletics for _____ High School. I hereby consent to necessary medical services that may be required while said child is under the supervision of an employee of the fore-mentioned high school while on a school-sponsored activity, and hereby appoint said employee to act on behalf of myself in securing medical services from any duly licensed medical provider. Signatures on this form do not constitute consent for vaccinations of any kind.

_____ _____

**Signature of Parent** **Date**

**CONSENT OF PARTICIPANT (for all students to complete):**

I, _____, have read the above consent for medical treatment form signed above, or, as an individual of majority age, consent to those same medical services and actions as indicated above on this form.

_____ _____

**Signature of Student** **Date**

# SDHSAA CONSENT FOR MEDICAL RELEASE FORM (HIPAA)

**Student Name: _____ Grade: _____ Date of Birth: _____**

**I/We the undersigned do hereby:**

1. Authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information for the purposes of evaluating, observing, diagnosing and creating treatment plans for injuries that occur during the time period covered by this form, or, from pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the medical care of this student.

3. This information for which I/we are authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire on July 1, 2025.

6. I understand that once the above information is disclosed, there is potential for it to be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Schools, School districts and school personnel are to uphold the bounds of FERPA. As such, disclosure and re-disclosure by schools or school employees must be done in compliance with FERPA guidelines.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

_____ _____

**Signature of Parent** **Date**

_____ _____

**Signature of Student (if over 18 or turning 18 before July 1, 2025)** **Date**

**This form must be completed annually and must be available for inspection at the school**

## SDHSAA CONCUSSION FACT SHEET FOR STUDENTS-

***What is a concussion?***

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

***What are the symptoms of a concussion?***

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

***What should I do if I think I have a concussion?***

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

***How can I prevent a concussion?***

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow you coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

**IT IS BETTER TO MISS ONE GAME THAN A WHOLE SEASON – SEE SOMETHING – SAY SOMETHING!!!**

| _____ | _____ |
|---|---|
| **Student's Name (Please Print)** | **Date** |
| _____ | _____ |
| **Signature of Student** | **Date** |
| _____ | _____ |
| **Parent's Signature** | **Date** |

## SDHSAA CONCUSSION FACT SHEET FOR PARENTS-

***What is a concussion?***

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

***What are the signs and symptoms?***

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

| Signs Observed By Parents or Guardians | Symptoms Reported by Athlete |
|---|---|
| • Appears dazed or stunned<br>• Is confused about assignment or position<br>• Forgets an instruction<br>• Is unsure of game, score, or opponent<br>• Moves clumsily<br>• Answers questions slowly<br>• Loses consciousness (even briefly)<br>• Shows mood, behavior, or personality changes<br>• Can't recall events prior to hit or fall<br>• Can't recall events after hit or fall | • Headache or "pressure" in head<br>• Nausea or vomiting<br>• Balance problems or dizziness<br>• Double or blurry vision<br>• Sensitivity to light or noise<br>• Feeling sluggish, hazy, foggy, or groggy<br>• Concentration or memory problems<br>• Confusion<br>• Just not "feeling right" or is "feeling down" |

***How can you help your teen prevent a concussion?***

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

***What should you do if you think your child has a concussion?***

1. **Keep your child out of play.** If your child has a concussion, her/his brain needs time to heal. Don't let your child return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your child is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
3. **Teach your child that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your child convince you that s/he's "just fine".
4. **Tell all of your child's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your child has ever had a concussion. Your child may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your child's coaches, school nurse, and teachers. If needed, they can help adjust your child's school activities during her/his recovery.

_____ _____

**Parent's Name** **Date**

_____ _____

**Signature of Parent** **Date**

_____

**Student's Name**

MONUMENT HEALTH

* E C O N O T H *

# Athletic Training Consent and Release - Minor



Patient
Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN #: _____

**General Information:**

School Grade:_____

Sports: _____

**Medical Information:**

Patient Name:_____ Date of Birth:_____

Medical Illnesses:_____

Allergies:_____

Medications:_____

*(any medications that may need to be taken during competition requires a provider's note)*

Previous neck/back injuries:_____

Previous Concussions:_____

Previous heat-related problems:_____

Previous surgeries:_____

Other information necessary to inform the medical staff:_____

**Release of Liability**

By undersigning below, I fully release, indemnify and hold harmless Monument Health , Inc., its affiliates and subsidiaries, its officers, directors, employees, volunteers, providers, agents, volunteer instructors and landlords (herein "Released Parties"), from any and all liability, claim and expense of any kind including, but not limited to, attorney's fees, related to any injury to my child including permanent injury or death that is caused in any manner, including those claims of negligence by the Released Parties or any other participant, by my participation in this athletic training program.

I intend for this Release to apply to my child's current and future participation in the above program, which shall remain in effect throughout his/her participation in the athletic training program. If I intend to revoke this release I agree to provide written notice to Monument Health, Inc. I understand this revocation shall not be effective until it is actually received by the CEO of Monument Health. I acknowledge I am fully aware of the nature of the athletic training program; what the athletic training program entails in terms of its impact upon the human body; the purpose of the athletic training program; the design of the athletic training program; the risks and the type of physical activity required for participation in the athletic training program. I understand it is my responsibility to have my child examined by a provider to determine my child's fitness for participation in this athletic training program. I agree my child is able to participate in this athletic training program and I choose for him/her to do so. I understand there may be exercise routines or other flexibility and stretching routines which might have an impact on my child's cardiovascular system, flexibility, balance, coordination, muscle toning and endurance. I acknowledge participants are advised to pace themselves during the course of the routines. I acknowledge the instructors and volunteers organizing this athletic training program are not responsible for monitoring my child's health conditions before, during, or after participation in the athletic training program. I acknowledge it is my responsibility to immediately seek medical care if needed for my child.

I accept full responsibility for my child's participation in this athletic training program and I waive any claim that the instructors or leaders for this athletic training program failed to properly supervise my child or train my child prior to or during my participation.

I acknowledge I have been advised to consult with my medical provider before participating in the athletic training program regarding any past or present injury, illness, cardiovascular problem, knee problems, or any other medical condition that may affect my child's participation and ability to participate in and to endure this or any exercise program .

MONUMENT HEALTH

* E C O N O T H *

# Athletic Training Consent and Release - Minor



Patient
Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN #: _____

**Consent for Athletic Conditioning, Training and Health Care Procedures**

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary treatment, including first aid, diagnostic procedures and medical treatment that may be provided by treating providers, nurses and other healthcare providers. In the event that I cannot be reached in an emergency, I hereby give permission for my child to be transported to receive necessary medical treatment.

Is your son/daughter covered under a medical insurance policy? ☐ Yes ☐ No

If so, what company?_____

---

**Sway Medical Consent**

**CONSENT FOR CONCUSSION TESTING and RELEASE OF INFORMATION**

I give my permission for (name of child)_____ (child's DOB)_____ to have a baseline Sway Medical test performed. In addition, I give my permission for my child to have post-concussion Sway Medical administered at (name of school) _____ if needed. I understand that my child may need to be post-concussion tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at (name of school) _____
I understand there is no charge for the testing.

(Name of school) _____ may release the Sway Medical results to my child's primary care provider, neurologist, or other treating provider, as indicated below.

I understand general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____ Name of practice or group:_____

Phone Number:_____

Parent or guardian phone numbers (please indicate preferred contact number and time if necessary):

Home:_____ Work:_____ Cell:_____

---

Patient Name PRINTED: _____

Patient Signature: _____ Date: _____ Time: _____

---

Parent/Guardian Name PRINTED: _____

Parent/Guardian Signature:_____ Date: _____ Time: _____

---

Witness for Obtaining Telephone Consent Name PRINTED: _____

Witness Signature:_____ Date: _____ Time: _____