Somerset Hills Bulldogs

PO Box 92
Basking Ridge, NJ 07920
www.somersethillsbulldogs.com

Physician's Report

Name & Age:

______________________ ______________________ ______________ ______________
(Last name) (First name) (Date of birth) (Age as of 7/31st)

Address:

______________________ ______________________ ______ ______
(# and street) (City) (State) (Zip)

Date of Examination: ____________ **Height**: __________ **Weight**: ____________

Blood Pressure: ____________ **Vision**: ____________

Medical History, esp. medications, allergies, respiratory problems, etc.: ______________________________

Comments and medical concerns:

____
____
____
____

Physicians Signature: ______________________

Important: Please attach a copy of Birth Certificate. Originals not needed.

Somerset Hills Bulldogs

Youth Football & Cheerleading Program

Medication Administration Request

(Prescription and Over Counter)

Date:_______________

Participant's Name:______________________________ Team/Squad: ___________

☐ Football ☐Cheer

Date of Birth: ____________________

Medication: ____

Dosage: ____

Time: ____

Reason for Medication: ____

Any Side Effects or Adverse Reactions? ___________________________________

Physician's Name: (Please Print) ____

Physician's Signature: ____

Physician's Phone Number: _______________________

To Be Signed by Parent/Guardian

I give my permission for the above medication to be administered to my child at any Somerset Hills Bulldog event/activity. I realize that any changes or modifications of this order will require a written authorization from this physician.

Parent/Guardian's Signature: ____

Date: _______________________

Somerset Hills Bulldogs

Youth Football & Cheerleading Program

Authorization for Self-Administration of Emergency Medications

(Epi-Pens & Inhalers Only)

Date:______________

Participant's Name:_____________________________ Team/Squad: ___________

☐ Football ☐Cheer

Date of Birth: ___________________

Medication: ____

Dosage: ____

Time: ____

Reason for Medication: ____

Any Side Effects or Adverse Reactions? _________________________________

I hereby certify that the child listed above has been instructed in and is fully capable of the self-administration of the above emergency medication.

Check all that apply: ☐ Self Administer
☐ Allow Qualified Staff to Administer Medication

The child is capable of carrying this medication during Somerset Hills Bulldog practices/games and all events, and to self-administer it.

Physician's Name: (Please Print) ____

Physician's Signature: ____

Physician's Phone Number: ______________________

Parent/Guardian's Signature: ____

SOMERSET HILLS BULLDOGS

Parent / Guardian Consent to Treatment of Athlete

I, ____, the undersigned parent / guardian of ____ (Name of Student)
A minor, do hereby authorize the Somerset Bulldogs Certified Athletic Trainer on my behalf to consent to any medical treatment deemed necessary by any licensed physician / surgeon in the event of illness or injury to the above named minor.

This consent to treat is intended to cover any illness or injury sustained while participating in any Bulldog athletic competition or practice.

If, in the judgment of any representative of the organization, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, trainer, nurse, hospital, or organization representative; and I do hereby agree to indemnify and save harmless the organization and any organization representative from any claim by any person whomsoever on account of such care and treatment of said student.

These authorizations shall remain effective until the end of the 2011 season.

____ ________________________

Parent / Guardian Signature Date

SOMERSET HILLS BULLDOGS

Informed Consent Form

The student athlete and/or a parent or guardian, if the student athlete is a minor, must read carefully and sign.

Athlete's Name: ______________________________ Sport: _________________________

I am aware that playing, or practicing to play, any sport can be dangerous, involving many risks of injury. I understand that the dangers and risks of participating in the above sport may include, but are not limited to; serious bodily injury which may include loss of limb, loss of sensory function (i.e. sight, hearing, etc.), permanent physical impairment, paralysis, or even death. With this understanding I assume the risk of participation in the above sport with the Somerset Hills Bulldogs.

Because of the dangers of participating in the above mentioned sport, I recognize the importance of following the Somerset Hill Bulldog's Team Physicians', Certified Athletic Trainers' and Coaches' instructions concerning playing techniques, conditioning, rehabilitation, and team rules. I agree to report all injuries to the Somerset Hills Bulldogs Certified Athletic Trainer and to follow the recommendations of the Team Physician and/or Certified Athletic Trainer regarding participation.

I understand that my personal medical information may be discussed amongst the Somerset Hills Bulldogs Team Physician, Certified Athletic Trainer, and Coaches as they deem necessary.

Athlete Signature: ____ Date: ____________

Parent/Guardian Signature: ____

Dear Parent/Guardian,

Somerset Hills Bulldogs Football and Cheerleading programs are currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

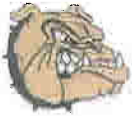
The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to a local doctor or, to help evaluate the injury. The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Somerset Hills Bulldogs Board, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact me at mary.housel.nj@gmail.com or call me at (908) 577-2262.

Sincerely,

Mary B. Housel, MS, ATC, ATL, CSCS
Certified Athletic Trainer
Director of Health and Safety
Somerset Hills Bulldogs



Consent Form

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Printed Name of Athlete ______________________________

Sport ______________________________

______________________________ ______________________

Signature of Athlete Date

______________________________ ______________________

Signature of Parent Date