Athletic Pre-Participation Physical Form

PLEASE PRINT

ATTENTION: PLEASE SIGN ALL (3) **BOLD** SIGNATURE BOXES

Name_____ **School**

_____ **First Middle Last**

2018-19

Gender: M F **Age:** _____ **Grade:** _____ **Date of Birth:** ____/_____/_____ **Sport(s):**_____

Address_____**City**_____**State**_____ **Zip**_____

Student Cell _____ **Family Physician**_____ € None

In case of emergency, parent/guardian contact

Name_____**Relationship**_____

_ Phone (H) _____ **(W)**_____

C)_____

Insurance: The school district for your student furnishes an Interscholastic Athletic Insurance Policy which provides limited benefits for all students in the system who participate in high school sponsored and supervised athletic activities. The policy provides excess coverage for students with other insurance coverage, but it will pay only when other benefits have been utilized. In cases which a student has no other coverage with either a commercial insurance company, Medicare, or Medicaid, the school athletic insurance policy will be the primary.

If your son or daughter should be injured while participating in a high school sponsored interscholastic athletic event, the following procedures must be followed to process a claim under the insurance provided by the school district: • See the athletic trainer or coach to ascertain the nature of the injury and if needed see a physician within 90 days of the injury

• Pick up an Accident Claim Form from school personnel (Athletic Director or Athletic Trainer). • Complete and submit the Accident Claim Form. This form must be filed with the insurance company within 90 days of the date of the injury. Please list the name of your primary insurance carrier and the policy number or indicate that you do not have any insurance.

€ None _____ _____

Name of Insurance Company Policy Number

Risk of Injury, Permission and Acknowledgement to Participate: As the parents or legal guardian of the above mentioned student I give my consent for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I grant permission for treatment deemed necessary for a condition arising during participation in these events, including medical or surgical treatment recommended by a medical doctor. I grant permission to nurses, certified athletic trainers, and coaches as well as physicians or those under their direction who are part of the athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from competition and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date:

CONCUSSIONS AND STUDENT-ATHLETES

After reading the Concussion and Student-Athletes Fact Sheet for Parents/Legal Guardians and Student Athletes information I am aware of the following:

Student-Athlete Initials		Parent/Guardian Initials
	A concussion is a brain injury and should be reported to my coaches, athletic trainer, and parents.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance	
	A concussion may not be "seen." Some symptoms may not present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parent, coach, or athletic trainer about my injuries and illnesses.	NA
	If I think a teammate has a concussion, I should tell my coaches, parents, or athletic trainer about the concussion.	NA
	I will not return to play in a game or practice if a hit to my head or body causes any concussion related symptoms.	NA
	I will/my child will need written permission from a medical doctor trained in concussion management to return to play following a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not/cannot provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is more likely to sustain another concussion or more serious brain injury if return to play or practice occurs before symptoms are fully resolved.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the concussions and Student Athletes Form.	

I have read and understand the above information regarding concussions

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Return to Play Progression: Once cleared by a physician, the student-athlete will be returned to play in a stepwise fashion. These rules follow current best practices and are consistent with the NATA 2014 position statement for concussion management. Progression should be under the guidance of a coach or medical professional.

Day 1: Low levels of physical activity (i.e. symptoms do not come back during or after the activity). This includes walking, light jogging, light stationary biking, and light weightlifting (low weight – moderate reps, no bench, no squats).

Day 2: Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate intensity on the stationary cycle, moderate intensity weightlifting (reduce time and or reduced weight from your typical routine).

Day 3: Heavy non-contact physical activity. This includes sprinting/running, high intensity stationary cycling, completing the regular lifting routine, non-contact sport specific drills (agility – with 3 planes of movement).

Day 4: Sports specific, non-contact practice

Day 5: Full contact participation (Preferably in a controlled practice setting)

Day 6: No restrictions

MEDICAL HISTORY

Student's Name: _____ Age: _____ School: _____

***** PARENTS/GUARDIANS: <u>Please assure all questions are answered to the best of your knowledge</u>. Not disclosing accurate information may put your child at risk during sports activity.**

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below (check all that apply): ___Anemia ___ Diabetes ___ Asthma ___Infections ___ Other		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Do you or someone in your family have sickle cell trait or disease? Who? _____		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Has a doctor every told you that you have any heart problems? If so, check all that apply: ____ High blood pressure _____ A heart murmur ____ High cholesterol _____ A heart infection ____ Kawasaki disease Other:_____		
10. Has a doctor ever ordered a test for your heart? (Ecg/Ekg, echocardiogram, etc.)		
11. Do you get lightheaded or feel more short of breath than expected during exercise?		
12. Have you ever had an unexplained seizure?		
13. Do you get more tired or short of breath more		

MEDICAL QUESTIONS	Yes	No
27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
28. Have you ever used an inhaler or taken asthma medicine?		
29. Is there anyone in your family who has asthma?		
30. Were you without or are you missing a kidney, eye, testicle, spleen, or any other organ?		
31. Do you have groin pain or a painful bulge or hernia in the groin area?		
32. Have you had infectious mononucleosis in the last month?		
33. Do you have any rashes, sores, or other skin problems?		
34. Have you had a herpes or MRSA skin infection?		
35. Do you have a history of seizure disorders?		
36. Have you ever had a head injury or concussion? If yes, how many have you had? (list dates) _____		
37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Have you ever become ill while exercising in the heat?		
42. Do you get frequent muscle cramps when exercising?		

quickly than your friends during exercise?					
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**	43. Have you had any problems with your eyes or vision?		
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			44. Have you had an eye injury?		
			45. Do you wear glasses or contact lenses?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			46. Do you wear protective eyewear, such as goggles or a face shield?		
			47. Do you worry about your weight?		
			48. Are you trying to or has anyone recommended that you gain or lose weight?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			49. Are you on a special diet or do you avoid certain food?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			50. Have you ever had an eating disorder?		
BONE AND JOINT QUESTIONS	**Yes**	**No**	51. Do you have any concerns you'd to discuss with the doctor?		
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			**FEMALES ONLY**	Yes	No
			52. Have you ever had a menstrual period?		
19. Have you ever had any broken, fractured or dislocated joints?			53. How old were you when you had your first period?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			54. How many periods have you had in the last month?		
21. Have you ever had a stress fracture?			Explain "Yes" answers:		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			_____ _____ _____		
23. Do you regularly use a brace, orthotics, or other assistive device?			_____		
24. Do you have a bone, muscle, or joint that bothers you?			_____		
25. Do any joints become painful, swollen, warm, or red?			_____		
26. Do you have any history of arthritis or tissue disease?			*****PARENTS SIGN LAST PAGE BELOW**		

I have reviewed and answered each question on the previous page, and assure that all responses are accurate. **Signature of Student:** _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Physical Examination: to be completed by a licensed physician, nurse practitioner or physician's assistant:

Student's Name: _____ Date of Birth: _____ Sport(s): _____

Height _____ Weight _____ Vision R/20_____L 20/_____ Corrected: □Y □N Pulse _____

BP (R arm) seated _____/_____ BP Re-Check (R arm) seated _____/_____

□ This section to be completed by Physician

Medical	**Normal**	**Abnormal Findings**
Appearance • Marfan Stimata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph Nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis, etc.		
Neurologic [c]		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

Functional Movement		

[a] Consider ECG, echo, and referral to cardiology for abnormal cardiac history or exam; [b] Consider GU exam in private setting with third party; [c] Consider cognitive evaluation or testing if significant concussion history.

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for_____

❑ NOT cleared □ □ ❑ Pending further evaluation ❑ For any sports ❑ For certain sports Reason:

_____

Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) outlined above. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are explained to the student (and parents/guardians) and parents/guardians have had the opportunity to ask questions.

Name of Physician (print/type) _____

Date_____ Address _____ Phone

_____ Signature of physician _____,

MD / DO / NP / PA