

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.  
 Medicines  Pollens  Food  Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. 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)?		
14. 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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. 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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
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?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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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 \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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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 \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- 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, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use 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 supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / ( / )	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PM)</li> </ul>		
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>		
Lungs		
Abdomen		
Genitourinary (males only) <sup>2</sup>		
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>		
Neurologic <sup>3</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>		

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>2</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>3</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- 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 preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

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 preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_  
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Other information \_\_\_\_\_  
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Check: MS East \_\_\_\_\_ MS West \_\_\_\_\_

**LEE COUNTY MIDDLE SCHOOL  
PARENTAL CONSENT FOR PARTICIPATION AND EMERGENCY  
MEDICAL TREATMENT**

**SPORT**

\_\_\_\_\_

The purpose of this document is to give my consent for my child to participate in athletics, to be transported to and from events, and if needed, to receive emergency medical transportation and treatment.

STUDENT' NAME \_\_\_\_\_ GRADE: \_\_\_\_\_

I understand that in the event of a serious injury or sudden illness occurring to my child, every prudent effort will be made by the school and/or medical staff to contact me. If I cannot be contacted, this document (or photocopy) will serve as my parental/guardianship consent for medical treatment. I ALSO UNDERSTAND THAT THE SCHOOL DOES PROVIDE INSURANCE FOR ATHLETICS IF I WISH TO PURCHASE IT. I ALSO VERIFY THAT MY CHILD IS COVERED BY INSURANCE THAT WILL COVER ANY TREATMENT CAUSED BY INJURY, WHICH IS THE PRIMARY INSURANCE CARRIER.

\_\_\_\_\_  
PARENTAL/GUARDIAN NAME ( Please Print )

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Cell Phone Number ( Parent/Guardian ): Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Other ( Emergency ) Phone Number: \_\_\_\_\_

**INSURANCE INFORMATION**

Athlete's Name \_\_\_\_\_ Cell Number \_\_\_\_\_

Birthdate \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Email: \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Allergies \_\_\_\_\_

# STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL: \_\_\_\_\_

## DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

## COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include, licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

- a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.
- b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at [www.nfhslearn.com](http://www.nfhslearn.com) at least every two years – beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

***I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.***

SIGNED: \_\_\_\_\_  
(Student)

\_\_\_\_\_  
(Parent or Guardian)

DATE: \_\_\_\_\_