Berean Baptist Academy

PREPARTICIPATION PHYSICAL EVALUATION

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam _____

Name _____ Date of birth _____ Sex _____ Age _____ Grade _____ School _____ Sport(s) _____ Address _____ Emergency Contact: _____ Relationship _____

Phone (H)_____(W)_____(Cell)_____(Email)_____

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) 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 anyreason?		
2. Do you have any ongoing medical conditions? If so, please identifybelow: Asthma Anemia Diabetes 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, checkall that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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 friendsduring 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, arryhthmogenic 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 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 neckinstability or atlantoaxial instability? (Down syndrome or dwarfism)		

BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
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, swolllen, 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?		41. Do you get frequent muscle cramps when exercising?		
27. Have you ever used an inhaler or taken asthma medicine?		42. Do you or someone in your family have sickle cell trait or disease?		
28. Is there anyone in your family who has asthma?		43. Have you had any problems with your eyes or vision?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males),		44. Have you had an eye injury?		
your spleen, or any other organ?		45. Do you wear glasses or contact lenses?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		46. Do you wear protective eyewear, such as goggles or a face shield?		
31. Have you had infectious mononucleosis (mono) within the past month?		47. Do you worry about your weight?		
32. Do you have any rashes, pressure sores, or other skin problems?		48. Are you trying to gain or lose weight? Has anyone recommended that you do?		
33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		49. Are you on a special diet or do you avoid certain types of foods?		
34. Have you ever had a head injury or concussion?		50. Have you ever had an eating disorder?		
35. Have you ever had a hit or blow to the head that caused confusion,		51. Do you have any concerns that you would like to discuss with a doctor?		
prolonged headaches, or memory problems?		**FEMALES ONLY**		
36. Do you have a history of seizure disorder or epilepsy?		52. Have you ever had a menstrual period?		
37. Do you have headaches with exercise?		53. How old were you when you had your first menstrual period?		
38. Have you ever had numbness, tingling, or weakness in your arms or		54. How many periods have you had in the last 12 months?		
legs after being hit or falling?				
39. Have you ever been unable to move your arms or legs after being hit or falling?		**Explain "yes" answers here**		
40. Have you ever become ill while exercising in the heat?				

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____Signature of parent/guardian_____Date: _____

The student has family insurance Yes No If yes, family insurance company name and policy number: _____

Berean Baptist Academy
PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS

SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

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 a 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 have 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

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

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____Signature of parent/guardian_____Date: _____

Berean Baptist Academy
Physical Examination Form

Name _____ Date of birth _____

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, 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 or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION DATE OF EXAMINATION _____		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance Marfan stigmata (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 Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		

Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

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 pre-participation physical evaluation. The student 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. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. 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 completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) _____ Date of Exam

_____ Address _____ Phone

_____

Signature of physician/medical examiner _____, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician _____Phone

_____ In case of Emergency, contact _____

Phone _____

Allergies_____

__

_____

__

_____

__

_____

__

_____

__

_____

Other Information

PREPARTICIPATION PHYSICAL EVALUATION

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

BBA **AUTHORIZATION FORM**

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____

__ Student's Signature Birth date of Student, including year

_____

__ Name of Student's personal representative, if applicable

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____

__ Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Fuzzy or blurry vision	Sensitivity to noise or light	more
Taking longer to figure things out	Feeling sick to your stomach/queasy	Irritability-things bother you more easily	Sleeping more than usual Sleeping
Difficulty concentrating	Vomiting/throwing up	Sadness	less than usual Trouble falling asleep
Difficulty remembering new information	Dizziness	Being more moody	Feeling tired
Headache	Balance problems	Feeling nervous or worried Crying	

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

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Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)

Parent/Legal Custodian Name(s): (please print)

Student Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after 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 a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student

Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

Signature of Student-Athlete Date

Signature of Parent/Legal Custodian Date

Rev May 2016