PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

EXAMINATION			
Height	Weight	☐ Male ☐ Female	
BP / (/)	Pulse	Vision R 20/ L20/	Corrected ☐ Yes ☐ No
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[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			
Neurologic[c]			
MUSCOSKELETAL			
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, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] 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 participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolve 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

HISTORY FORM

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

Name _____ Sex __F __M Age ___ Date of Birth _____ Grade ____

School _____ Sport(s) _____ Date of Exam _____

Address _____ Phone _____

EMERGENCY CONTACT NAME _____ Relationship _____ Phone _____

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

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 ☐ 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, check all 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 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. Doe 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	**Yes**	**No**
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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission 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 also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, athletic trainers and coaches as well as physicians or those under their direction who are part of 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 play 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 to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ **Date** _____

Signature of parent/guardian _____ **Date** _____

SPARTANBURG SCHOOL DISTRICT THREE
CONCUSSIONS AND STUDENT ATHLETES

Fact Sheet for Parents/Legal Guardians and Student Athletes

Note: Parents/Legal Guardians and student athletes are required to read and sign this form. Return this form to the appropriate Team Coach or Athletic Trainer.

WHAT IS A CONCUSSION?

The CDC defines a concussion as, "a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells".

Parent/Legal Guardian's Responsibility

If your child reports signs or symptoms of a concussion, please notify the athletic trainer and seek medical attention immediately. Below are possible signs and symptoms of a concussion:

- appears dazed, stunned or disoriented; demonstrates decreased alertness
- loses consciousness (even briefly)
- has memory/ recall difficulties
- answers questions slowly or slurs words
- shows behavior or personality changes
- has headaches or head pressure
- demonstrates balance deficits or dizziness
- experiences seizures or vomiting

Return to Play Protocol

IF your child is diagnosed with a concussion, they must first return to baseline then, once symptom free for at least 24 hours, complete a stepwise return to play progression protocol. The protocol must be completed under the supervision of the athletic trainer. Each step must be at least 24 hours apart. If symptoms arise, the participant may not progress to the next step and must be reevaluated by a healthcare professional. The protocol is as follows*:

- Step 1: Low levels of physical activity (i.e. walking, light jogging, biking)
- Step 2: Moderate levels of physical activity (i.e. moderate jogging, moderate biking, etc.)
- Step 3: Heavy non-contact physical activity (i.e. sprint drills, agility drills, weightlifting, etc.)
- Step 4: Sports specific non-contact practice (i.e. individual noncontact drills)
- Step 5: Full contact in a controlled practice
- Step 6: Return to competition

Student Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

For more information on concussion and traumatic brain injury, visit www.cdc.gov/traumaticbraininjury/

**subject to change*

Sports Medicine Institute
A Division of Spartanburg Regional Healthcare System

Spartanburg Regional Health Services District, Inc.
General Consent to Treat and Release

Consent for Medical Treatment. I, the student/athlete named below (if over the age of 18) (the "Student"), or parent/legal guardian of the Student, hereby authorize and grant permission to Spartanburg Regional Health Services District, Inc. (the "District"), including without limitation its employed sports medicine personnel and certified athletic trainers, (the "District Employees"), to provide to the Student any treatment or medical care that they deem reasonably necessary to the health and wellbeing of the Student, including without limitation medical, surgical and diagnostic procedures. I also hereby authorize the District Employees to render to the Student any preventive, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and wellbeing of the Student. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made as to the result of treatments or examinations. I understand and acknowledge that the Student is not being compelled to utilize the services of the District Employees, and that the Student is free to seek medical care and treatment from any provider of his or her choosing.

Consent for Release of Information. I hereby authorize the District, its officers, employees, and agents to release information regarding Student's protected health information and any related information regarding any injury or illness during Student's training for and participation in school/club athletics. This protected health information may concern Student's medical status or condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information (the "PHI"). This PHI may be released to other health care providers and laboratories, athletic coaches and/or school/club administrators, medical insurance coordinators and insurance carriers, as well as any federal or state regulatory agencies as required by law. I hereby fully discharge all parties to whom this authorization extends from any and all privilege in connection with the disclosure of information included in this authorization to release information. I understand that I may revoke this authorization/consent at any time by notifying in writing the District Regional Sports Medicine Manager, but if I do, it will not have any effect on actions that the District took in reliance of this authorization/consent prior to receiving the revocation. This authorization/consent expires one (1) year from the date it is signed.

Acknowledgment of Receipt of Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices, describing how my PHI may be used or disclosed. I understand that I should read it carefully, and that it may be accessed at www.srhs.com.

Waiver of Claims. In consideration for the care and treatment provided by the District Employees, I hereby release and hold harmless the District, its officers, employees and agents from and against any claim, cause of action or other expense arising out of the services provided by the District Employees, except to the extent that such claims arise out of the District's gross negligence or intentionally injurious acts.

_____
Printed Name of Parent/Guardian or Legally Authorized Representative

_____
Relationship to Student

_____
Signature of Parent/Guardian (if Student is under 18 years of age)

_____
Name of Student

_____
Date

OGC