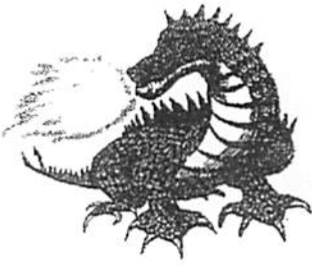


# Pickens High School
## *Pursuing Higher Standards*

Dear Parent or Guardian,

In an effort to communicate with you about what the Pickens High School (PHS) Athletic Department values, I have copied two very important items of information. The PHS Athletics Mission Statement was created to show you and your student athlete the high standards that we have at PHS. The PHS Athlete Rule is something that was created many years ago and is followed by most high school athletic departments in the state of Georgia. Its purpose is to not only teach commitment to our student athletes, but also to keep any inter-sport issues from occurring. It is my hope that you read each of these statements as a testament to the quality program we hope to provide your child at PHS. GO DRAGONS!!!

Sincerely,

Chris Parker
District Athletic Director

Athletics Mission Statement:

Our mission is to offer region and state-wide athletic teams which reflect the interests of our students, and to further provide a worthwhile and positive athletic experience for our student-athletes by teaching them the basic principles of excellent competition, competitive integrity, unselfish play, and equal opportunity. At Pickens High School, we want to strive to better ourselves on the field of play, in preparation and in the classroom. Most of all, we want to offer a superior athletic program to each of our student athletes in order to prepare them in becoming the best young men and young women that they can be. We do this by being loyal members of the Dragon Family!

PHS Athlete Rule:

If a student athlete begins a season with one sport and quits playing, they will not be allowed to participate in any sport for the remainder of that season, unless cleared to do so by the AD or principal.

500 Dragon Drive • Jasper, Georgia 30143 • (706) 253-1800 • Fax: (706) 253-1815
www.pickenscountyschools.org

Parents,

This letter is meant to explain to you each form in this PHS Athletic Packet. ***Please make sure you have checked both sides of each paper and filled out the appropriate information on each sheet.*** Included in this packet is the Emergency Medical Authorization form that will allow the coaches to transport your child to the hospital and receive treatment in the case of an emergency. You will be contacted before transport is made. As a result of that, we also have included the PHS Insurance Information Form. ***All PHS athletes are required to have health insurance in order to participate.*** An "Athletic Insurance" plan is available to football players. The school insurance plan is available to athletes participating in PHS sports other than football. Please notify the coach or school nurse if you are interested in purchasing the available insurance.

Due to the new GHSA Policy regarding heat and humidity, PHS has developed a Fluid Replacement Policy that the athlete themselves must fill out. The Physical Evaluation Form has been included and must be completed by a doctor. There is also a form concerning concussions. Please read over this with your child. The last form is the Permission to Treat/HIPAA Privacy Act form that would allow the athletic trainer to treat your child, as well as discuss any injuries/illnesses they have with those you deem appropriate.

Again, this packet was created to ensure the safety of your child while participating in PHS Athletics. **All of these forms are required for participation and must be filled out correctly before your child will be allowed to participate in any sport at PHS.** If you have any questions, please do not hesitate to contact me at Pickens High School (706) 253-1800. Thank you for your support of Pickens High School Athletics...and GO DRAGONS!!!

Sincerely,

Chris Parker
District Athletic Director

Kyle D. Rasco, EdS., ATC
Certified Athletic Trainer

**CHECK LIST:**

_____ Emergency Medical Authorization
_____ Insurance Information
_____ Fluid Replacement Policy
_____ HIPPA Document
_____ Concussion Form
_____ Physical Evaluation Form

***REQUIRED FOR PARTICIPATION***

Dear Parents:

As of August 1st, 2005, Pickens High School has had a full-time Certified Athletic Trainer (ATC) on staff. This position was created to ensure the safety and healthcare of your children, as well as our student athletes. This person will be responsible for many different domains of care including: prevention, emergency management, rehabilitation, taping & bracing, injury assessment, therapeutic treatment, nutrition and medical referrals. In order to become a certified athletic trainer, one must not only finish an accredited curriculum, but also pass the National Athletic Trainer's Association Board of Certification Examination.

Before your child participates in rehabilitation, treatment or is seen by a physician, you will be contacted for permission. This applies to any athlete under the age of 18. However, according to federal law (HIPAA & FERPA-Privacy Act) any treatment done on any person 18 or older does not require a guardian's permission and is a violation of that law if the athlete's Personal Health Information is discussed without the athlete's permission. For this reason, all athletes are required to sign an authorization form authorizing the certified athletic trainer to discuss the athlete's Personal Health Information with parents, coaches and physicians. If the athlete does not sign the Authorization Form, they will not be allowed to participate in PHS Athletics.

Again, this position was designed to offer your child the safest environment and care to participate in athletics. The ATC will be available, if not present, at all practices and games with every sport held at Pickens High School. By signing this form, you as the legal guardian are acknowledging that you have read the above information and are giving permission for your child to be medically treated in case of an emergency situation. If there are any medical conditions or medical history that you feel the ATC needs to be made aware of, please contact them immediately.

Student's Full Name: ______________________________

Legal Representative's Name: ______________________________

Signature: ____________________________ Date: ________________

- *If 18 or older, your signature is required.*

*(continue to next page)*

***REOURIED FOR PARTICIPATION***

**Pickens High School Sports Medicine**
**Student Athlete Authorization**

***Purpose:*** This form is used to authorize Pickens High School Sports Medicine to use or disclose your Personal Health Information (PHI) to the individual(s) or class(es) of persons you designate and for the Sports Medicine Department to disclose your PHI for the purposes stated on the completed form.

**Section A:** *Individual authorizing use and/or disclosure –Complete information.*
This authorization is good for one year from the date it is signed.

Last Name: ________________ First Name: ________________ MI: _____

**Section B:** *The Use and/or Disclosure Being Authorized*
The PHI to be disclosed will be injury and/or illness information that directly affects your participation in high school athletics. It is important for the student to understand that this authorization is all or none. If you give permission to disclose PHI, you give permission to disclose any PHI to any of the parties indicated below within the discretion of the Certified Athletic Trainer.

I hereby authorize Pickens High School Sports Medicine to disclose personal health information about me to the following entities: *initial next to each as they apply*

_______ Head/ Assistant Coach _______ Parent/ Legal Guardian

_______ Medical Providers _______ Professional/ Collegiate Teams

_______ Insurance Companies

I understand that it is necessary for head coaches, assistant coaches, & medical providers to have access to my PHI if I am to participate in high school athletics. Accordingly, I acknowledge that if I do not give permission for my PHI to be shared with these persons, I will not be allowed to participate in high school athletics at Pickens High School.

**Right to Revoke**: I understand that I may revoke this authorization at any time by giving written notice to the ATC. I also understand that by revocation of this authorization, it may affect my ability to participate in high school athletics at PHS.

**Media Disclosure**: You are not required to give PHI to the media as a condition for participation in athletics at PHS. PHI disclosed to the media will be done on a case by case and will require written permission by the athlete per injury/ illness.

**Section C:** Individual's signature

I, ____________________________(please print) have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my PHI as described on this form.

Signature: ____________________________________ Date:___________

Parent/Guardian signature (if under 18 yrs of age)___________________________

***REQUIRED FOR PARTICIPATION***

# Pickens High School Athletics: Emergency Medical Authorization

**Student's Name** ____________ **Date of Birth** ____________ **Grade** ____________

**Address** ____________ **Zip** ____________ **Emergency Telephone #** ____________

**Parent's/Guardian's Name** ____________ **Alternate Person** ____________

**Alternate's Telephone #** ____________

***Purpose: To enable parents to authorize emergency treatment for children who become ill or injured under school authority when parents cannot be reached***

## *Part I or II Must be Completed*

### Part I-TO GRANT CONSENT

In the event reasonable attempts to contact me(**parent's name)**________________________ at **(Phone #)**_____________________ or **(alternate person's name)**______________________ at **(alternate person's #)**__________________________ have been unsuccessful, I hereby give my consent to any member of the coaching staff of any treatment deemed necessary. I also grant consent to the coaches to transfer my child to Piedmont Mountainside Hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions or 2 other licensed physicians concurring in the necessity for such surgery are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted:______________________________
________________________________________________________________________
________________________________________________________________________

Signature of Parent or Guardian ____________ Date ____________

*(Continued on opposite side)*

***(Do not complete if you completed Part I)***

**Part II-REFUSAL TO CONSENT**

I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the coaches to take no action. If I cannot be contacted, I wish the coaches to take no action or to:______________________________
________________________________________________________________________
________________________________________________________________________

________________________________ ____________________
Signature of Parent or Guardian

***REQURIED FOR PARTICIPATION***

# PICKENS HIGH SCHOOL

## Students Application for Participation in Interscholastic Athletics and Verification of Insurance

This form is to be completed by the parent/guardian and student prior to the first practice session. This form is to accompany this athlete to all practices and contests. Parent(s) acknowledge that they have read and understand all the information provided when they sign this form. Failure to submit this form will delay the eligibility of the student athlete to join the team. Participation in supervised interscholastic athletics includes a risk of injury which may range in severity from minor to long-term. It is possible to minimize the risk, but not to eliminate it entirely. Participants can and have the responsibility to help reduce the risk of injury. Participants must obey all safety rules, report all physical problems to their coaches and the school's athletic trainer and inspect their equipment daily. By signing this permission form, you acknowledge that you have read and understand this warning. Parents or students who do not wish to accept the risks described in this warning should not sign the permission form.

Date:____________________________ Sport:____________________________

Student Name:____________________________________ Male/Female (circle one)

Address:________________________________________________________________

________________________________________________________________________

Home Telephone: ______________________ Emergency Telephone: ______________________

Parent/Guardian Names: ____________________________ Date of Birth________________

Grade Level: (circle one) 9 10 11 12

Student Signature: __________________________________________________________

I (We) hereby give our consent for ___________________________________ to represent his/her school in interscholastic athletics. I (we) understand the possible risks involved with participation in interscholastic athletics. If I (we) cannot be reached in the event of a medical emergency, I (we) do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities.

Signature of Parent/Guardian:___________________________________Date____________

Signature of Parent/Guardian:___________________________________Date____________

*(Continue to other side)*

***REQUIRED FOR PARTICIPATION***

**Important: All student athletes are required to have medical/health insurance in order to participate in the Pickens County Schools Interscholastic Athletics Programs.** Students must be enrolled in the medical/health insurance coverage that has been approved by the Pickens County School System or enrolled in substitute medical/health insurance through a bona fide insurance provider. Parent/guardian must verify substitute insurance coverage below.

## Verification of Insurance Coverage

I (We) have waived the medical/health insurance coverage that has been approved by the Pickens County School System and offered to my child

______________________________________.

The medical/health insurance that I am using for my child for the current school year is provided by (Name of Insurance Company)______________________________________

and the insurance policy number is______________________________________.

The insurance policy is in effect from _______________ to __________________.

I(We) certify that the insurance information provided is valid and current. I(We) acknowledge that it is My(Our) responsibility to notify the PHS Athletic Department of any change in My(Our) child's insurance coverage. Failure on My(Our) part to notify the PHS Athletic Department of any change in coverage or the falsification of insurance coverage will result in My(Our) full responsibility should my child be injured or require medical treatment while participating in PHS Athletics and I(We) hereby release PHS from any responsibility.

**ALL PARENTS/GUARDIANS MUST SIGN BELOW AND DATE:**

Signature of Parent/Guardian:__________________________ Date:__________________

Signature of Parent/Guardian:__________________________ Date:__________________

# Pickens High School
# Hydration & Fluid Replacement Policy

Heat illness is used to define several types of afflictions suffered when an individual experiences a rising body temperature and dehydration. Listed below are the different forms of heat illness defined by the NATA (National Athletic Trainers Association).

| Type | Symptoms | Treatment |
|---|---|---|
| Heat Cramps | • Muscle spasms due to imbalance in water and electrolytes. Usually affects the legs and abdominals | • Rest in a cool place<br>• Drink plenty of fluids<br>• Proper stretching<br>• Application of ice if needed |
| Heat Exhaustion | • Normal to high temperature<br>• Heavy Sweating<br>• Skin is flushed or cool and pale<br>• Headaches, dizziness<br>• Rapid pulse, nausea and weakness<br>• Physical collapse may occur<br>• Can occur without prior symptoms and may be a precursor to Heat Stroke | • Get to a cool place immediately out of the heat<br>• Drink plenty of fluids<br>• Remove excess clothing<br>• May immerse entire body in cool water |
| Heat Stroke | • Body's cooling system shuts down<br>• Increased core temperature of 104° or higher<br>• Sweating stops<br>• Shallow breath and rapid pulse<br>• Disorientation and loss of consciousness possible<br>• Possible irregular heart rhythm and cardiac arrest | • Call 911 Immediately<br>• Cool bath with ice packs near large arteries (neck, armpits and groin)<br>• Replenish fluids by drinking or intravenously if needed |

Cold water will be readily available during rest periods, which will be increased depending on the WBT. If a student requests water during an unscheduled time, they will be granted permission to hydrate themselves immediately.

Hydration and fluid replacement is a daily process. Students should hydrate themselves before, during and after practice and games. Meals should include an appropriate amount of fluid intake in addition to a healthy diet. Each student will be personally responsible for weighing themselves in and out, monitoring their water loss after each practice or event. The recommended intake for water loss during practice is listed in the next chart.

*REQUIRED FOR PARTICIPATION*

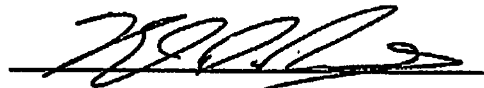
# FLUID REPLACEMENT

| *Weight Loss During Workouts* | *Fluid Amount Needed to Rehydrate* |
|---|---|
| 2 Pounds | 32 oz. (4 cups or 1 sports drink bottle) |
| 4 Pounds | 64 oz. (8 cups or 2 sports drink bottle) |
| 6 Pounds | 96 oz. (12 cups or 3 sports drink bottle) |
| 8 Pounds | 128 oz. (16 cups or 4 sports drink bottle) |

## Guidelines for Hydration During Exercise

1. *Drink 16-24oz. of fluid 1 to 1 ½ hours before the workout or competition.*
2. *Drink 4-8oz. of water or sports drink during every 20 minutes of exercise.*
3. *Drink before you feel thirsty. When you feel thirsty, you have already lost needed fluids.*
4. *Fluids that are appropriate for hydration are: water, sports drinks, some juices.* *Fluids that can cause dehydration are: sodas, tea, coffee, energy drinks*

**Please sign the appropriate area showing that you have read and understand Pickens High School's Hydration and Fluid Replacement Policy as required by the Georgia High School Association.**



**Chris Parker**
**District Athletic Director**

**Kyle D. Rasco, EdS., ATC**
**Certified Athletic Trainer**

______________________________
**Parent's Signature** **(Date)**

______________________________
**Student's Signature** **(Date)**

*REQUIRED FOR PARTICIPATION*

# PHS STUDENT/PARENT CONCUSSION AWARENESS FORM

## 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.

## 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 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.

***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.***

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

SIGNED: ______________________________ (Student) /DATE

______________________________ (Parent or Guardian)/DATE

# 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: ☐ 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. 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

____________________

____________________

____________________

**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 ____________

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HE0503 9-2681/0410

# 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

______________________________

______________________________

______________________________

______________________________

______________________________

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 athlete ______________ Signature of parent/guardian ______________ Date ______

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# PREPARTICIPATION PHYSICAL EVALUATION
# 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, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION | | |
|---|---|---|
| Height Weight ☐ Male ☐ Female | | |
| BP / ( / ) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• 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 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

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HE0503

9-2681/0410

# ▧ 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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