

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 _____ Date of birth _____

Name _____

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

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"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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. If conditions arise after the athlete had 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 _____, MD or DO

Signature of physician _____



SPARTANBURG DISTRICT 7 SPORTS HEALTH FORM

(PLEASE PRINT)

Athlete's Name _____ School _____

Sex _____ Age _____ Date of Birth _____ Grade _____ School Year _____

Mailing Address _____

City _____ State _____ Zip Code _____

Mother's Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Father's Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact (if parents cannot be notified): Name _____ Phone _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Preferred Hospital _____

HEALTH INSURANCE INFORMATION

Do you have health insurance? Yes / No Do you have Medicaid? Yes / No Medicaid # _____

Insurance Company Name _____ Policy # _____

Insured's Name _____ Mailing Address _____

*Spartanburg School District 7 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay secondarily to the athlete's primary health insurance. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing Spartanburg District 7, the athlete should seek the attention of the sports medicine staff as soon as possible. The athletic trainer (high school) or school official (middle school) will fill out the top portion of the insurance claim form (aka Notification of Injury Form). The parent/guardian should complete the claim form, followed the attached directions and mail the completed form to the insurance company. (Note: The claim must be filed within 90 days of injury.) I understand this information and will notify the head athletic trainer prior to the doctor's appointment if I require a claim form for an injury that meets the above requirements.

CONSENT OF MEDICAL TREATMENT / RELEASE OF INFORMATION

I/We give consent for certified athletic trainers, coaches, and physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to physicians, certified athletic trainers, and/or appropriate healthcare professionals to attend to my son/daughter. It is understood the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for our son/daughter to be evaluated and treated by the school's certified athletic training staff and/or team physicians if he/she becomes injured while participating as an athlete for Spartanburg District 7 during the school year. I/We also authorize the school's sports medicine staff to be given medical information concerning my son/daughter by a physician or their staff. Likewise, the school's sports medicine staff may release medical information to physician's offices, coaching staff, nurses, administrators and faculty within Spartanburg District 7 as they see appropriate. I also commit to reporting ALL injuries to the sports medicine staff including but not limited to any symptoms related to a concussion. I also understand the sports medicine staff will follow a return to play protocol for all injuries.

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 this is simply a screening evaluation and not a substitute for regular healthcare. I grant permission to nurses, certified athletic trainers and coaches as well as physicians or those under the direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know the risk of injury to my child 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.

Student's Signature _____ Parent's Signature _____

Date _____ Date _____

PARENT/STUDENT-ATHLETE CONCUSSION STATEMENT

___ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.

___ A concussion is a brain injury, which I am responsible for reporting to my athletic trainer.

___ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

___ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

___ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer.

___ I will not return to play in a game or practice if I have received a blow to my head or body that results in concussion-related symptoms.

___ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

___ In rare cases, repeat concussions can cause permanent brain damage, and even death.

___ I have read and understand the Concussion Fact Sheet for Parents and Student-Athletes.

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____ **Date** _____

Student Name: _____
(Please Print)

Student/Athlete Signature: _____ **Date** _____

HEADS*UP

CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Can occur during practices or games in any sport.
- Can happen even if you haven't been knocked out.
- Can be serious even if you've just been "dinged" or had your "bell rung."

How can I prevent a concussion?

It's different for every sport. But there are steps you can take to protect yourself from concussion.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets).

In order for equipment to protect you, it must be:

- Appropriate for the game, position, and activity
- Well maintained
- Properly fitted
- Used every time you play

How do I know if I've had a concussion?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up days or weeks after the injury. It's best to see a health care professional if you think you might have a concussion. An undiagnosed concussion can affect your ability to do schoolwork and other everyday activities. It also raises your risk for additional, serious injury.

What are the symptoms of a concussion?

- Nausea (feeling that you might vomit)
- Balance problems or dizziness
- Double or fuzzy vision
- Sensitivity to light or noise
- Headache
- Feeling sluggish
- Feeling foggy or groggy
- Concentration or memory problems (forgetting game plays)
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump, blow, or jolt to the head. Also, tell your coach if one of your teammates might have a concussion.
- **Get a medical check up.** A health care professional can tell you if you have had a concussion and when you are OK to return to play.
- **Give yourself time to recover.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause permanent brain damage, and even death in rare cases. Severe brain injury can change your whole life.

It's better to miss one game than the whole season.

DEPARTMENT OF HEALTH AND HUMAN SERVICES



HEADS+UP

CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even a "ding" or a bump on the head can be serious.

What are the signs and symptoms?

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or can take days or weeks to appear. If your teen reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

Signs Observed by Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> • Appears dazed or stunned • Is confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit 	<ul style="list-style-type: none"> • Headache • Nausea • Balance problems or dizziness • Double or fuzzy vision • Sensitivity to light or noise • Feeling sluggish • Feeling foggy or groggy • Concentration or memory problems • Confusion

What should you do if you think your teenage athlete has a concussion?

1. **Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
2. **Keep your teen out of play.** Concussions take time to heal. Don't let your teen return to play until a health care professional says it's OK! Athletes who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your teen for a lifetime.
3. **Tell all of your teen's coaches about any recent concussion.** Coaches should know if your teen had a recent concussion in ANY sport. Your teen's coaches may not know about a concussion your teen received in another sport or activity unless you tell them. Knowing about the concussion will allow the coach to keep your teen from activities that could result in another concussion.
4. **Remind your teen:** It's better to miss one game than the whole season.

It's better to miss one game than the whole season.

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