# Preparticipation Physical Evaluation - Physical Form

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

| **Examination** | | | | |
|---|---|---|---|---|
| Height: | Weight: | | | |
| BP: / ( / ) | Pulse: | Vision: R 20/ | L 20/ | Corrected ☐ Yes ☐ No |

| **Medical** | **Normal** | **Abnormal Findings** |
|---|---|---|
| **Appearance:**<br>Marfan stigmata (kyphoscoliosis, high–arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency | | |
| **Eyes / Ears / Nose / Throat**<br>- Pupils equal / Hearing | | |
| **Lymph Nodes** | | |
| **Heart**<br>- Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver | | |
| **Lungs** | | |
| **Abdomen** | | |
| **Skin**<br>- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis | | |
| **Neurologic** | | |
| **Musculoskeletal:** | | |
| - Neck | | |
| - Back | | |
| - Shoulders/Arm | | |
| - Elbow/Forearm | | |
| - Wrist/Hand/Fingers | | |
| - Hip/Thighs | | |
| - Knees | | |
| - Leg/Ankles | | |
| - Foot/Toes | | |
| - Functional: Double-leg squat test, single leg squat test, and box drop or step drop test | | |

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

**Preparticipation Physical Evaluation**

☐ Medically eligible for all sports without restriction.

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

_____

☐ Medically eligible for certain sports: _____

☐ Not medically eligible pending further evaluation.

☐ Not medically eligible for any sports.

Recommendations: _____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete had been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, NP, or PA

# Preparticipation Physical Evaluation - History Form

**Note: Complete and sign this form (with your parents if younger than 18) before your appointment.**

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _____

| **General Questions.** Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer. | **Yes** | **No** |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| **Heart Heath Questions About You** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography. | | |
| 9. Do you get lightheaded or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |
| **Health Questions About Your Family** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (*including drowning or unexplained car accident*)? | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QTsyndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | | |
| 13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35? | | |
| **Bone and Joint Questions** | **Yes** | **No** |
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice? | | |
| 15. Do you have a bone, muscle, ligament or joint injury that bothers you? | | |

| **Medical Questions** | **Yes** | **No** |
|---|---|---|
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? | | |
| 20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in the heat? | | |
| 23. Do you or someone in your family have sickle cell trait or disease? | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special Diet or do you avoid certain types of foods? | | |
| 28. Have you ever had an eating disorder? | | |
| **Females Only** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | | |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

Explain a "Yes" answer here: _____

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date _____

# School District of Newberry County Concussion Management Plan

## EDUCATION & ACKNOWLEDGEMENT

- The concussion fact sheet will be available as a part of the education process of athletes and their parents. Before being allowed to participate, all School District of Newberry County athletes and their parents must read the concussion fact sheet and sign the concussion awareness statement. By signing this statement, they acknowledge that they have read and understand the information and that it is their responsibility to report injury and illnesses to a staff athletic trainer, including signs and symptoms of a concussion.
- All School District of Newberry County coaches will complete the National Federation of High Schools course **"Concussion in Sports: What You Need to Know"** in accordance with South Carolina High School League rules.
- Coaches are not expected to "diagnose" a concussion. Each member of the athletic department staff should be aware of the signs, symptoms and behaviors of a possible concussion. If it is suspected that the athlete may have a concussion, then the athlete must be removed from all physical activity.
- When an athlete is concussed, an attempt to contact his/her parent will be made as soon as possible. Both parent and athlete should have further education in concussion management, including but not limited to the "Athlete Information" portion of the SCAT6 form and/or individual advice from the athletic training staff on concussion signs, symptoms and care.

## EVALUATION

- Any athlete experiencing symptoms should report them to the athletic training staff as soon as possible.
- Any athlete exhibiting signs, symptoms or behaviors consistent with concussion shall be removed from athletic activities by an athletic trainer (or coach in the absence of the athletic trainer) and evaluated by a medical staff member (staff athletic trainer or team physician) as soon as possible.
- A physical examination using a battery of neurological tests will be performed by a staff athletic trainer as soon as possible after the time of injury for all athletes exhibiting signs, symptoms or behaviors consistent with concussion.
- All concussed athletes should be evaluated by a team physician, or the physician of the parent's choice trained in concussion management.
- A concussed athlete should regularly report to the athletic training room for assessment of symptoms (ideally each school day). In the instance the concussed athlete is a middle school student, the assessments will be provided by the school nurse if transportation is a problem until the athlete is asymptomatic.

## RETURN TO PLAY CRITERIA

- Upon knowledge of a concussion, the concussed athlete will NOT return to play the same day.
- All concussed student athletes must be cleared by a physician trained in concussion management.
- Once a concussed athlete is asymptomatic the athlete will complete stepwise exertional testing over several days as described in the Zurich Consensus Statement. Upon successful completion of the stepwise program without recurring symptoms, the athlete may return to play.
    - *Day 1 - light aerobic exercise*
    - *Day 2- moderate aerobic exercise*
    - *Day 3 - heavy non-contact activity*
    - *Day 4 - sports-specific practice*
    - *Day 5 - full contact practice*
    - *Day 6 - return to competition*

  *Note: If the athlete experiences post-concussion symptoms during any phase, the athlete should drop back to the previous asymptomatic level/ and resume the progression after 24 hours.*
- In the event that a symptomatic athlete is cleared by a physician, the athlete will not return to play until the return to play protocol outlined in the consensus statement is followed and passed.

## OTHER CONSIDERATIONS

- The school nurse will be notified by a staff athletic trainer of a concussed athlete. The school nurse will notify the athlete's guidance counselor, and a notification will be made to the athlete's teachers. A concussion fact sheet and/or a list of classroom accommodations will be provided as needed.
- This plan will be updated and reviewed annually or as new standards of care become available.

**Mild Traumatic Brain Injury (MTBI) / Concussion Annual Statement and Acknowledgement Form for Student-Athletes**

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the appropriate school staff (e.g., coaches, athletic training staff, and school nurse). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I/we acknowledge:

- My school has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and the signs and symptoms.
- I/We have fully disclosed to the school medical staff any prior mild traumatic brain injuries (MBTI)/concussions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I/We am/are responsible for reporting to the coach, athletic trainer, school nurse, or other appropriate school medical staff member.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I will make every *effort* to report the injury to the appropriate school staff and/or school medical staff member.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- I understand return to play following a head injury requires following a graduated return to play protocol.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student-athlete must print their name, then sign and date below:

Print athlete's name: _____

Signature: _____ Date: _____

Parent/guardian must print their name, then sign and date below:

Print parent/guardian's name: _____

Signature: _____ Date: _____

# ATHLETIC RISK ACKNOWLEDGEMENT

Student Athlete's Name: _____Date of Birth: _____

My/our child wishes to participate in the athletic program at _____.

I/We understand that the risks include a full range of injuries, from minor to severe. We recognize the possibility that my/our child might die, become paralyzed or suffer brain damage or other serious, permanent injury from participation in this sports program. I/We realize that neither the protective equipment and padding used in athletic programs, the safety rules and procedures of the various sports, the coaching instruction received, nor the sports medicine care provided to athletes will guarantee safety or prevent all injuries he/she might sustain. I/we agree to accept these risks as a condition of my/our child's participation in this program.

In consideration for my/our child's participation in the program, I/we hold harmless and release the School District of Newberry County Schools and its employees, agents, coaches, volunteers, and trustees, from all present and future liabilities, expenses, damages, losses, injuries, judgements, and claims, of whatsoever, in equity or law, which I/we or my child may have, whether known or unknown, suspected or unsuspected, asserted or not asserted, arising out of participation by my/our child in the program.

**ADDITIONAL OR SPECIAL CONSIDERATIONS RISK ACKNOWLEDGEMENT**

***(Note: Fill this box out ONLY if your child has a pre-existing condition that may increase the injury and/or illness. If this section does not apply to you then write "Not Applicable" or "N/A" in the first space.)***

- I also realize that my/our child's _____ creates additional risks and I/we have discussed these risks with the athletic director, coach(es), and the sports medicine provider(s).
  Notes/Explanations/Recommendations- should be attached to this form

- I/we understand these concerns and agree to follow the directions and recommendations of my/our physicians and sports medicine providers in this program. I/we also agree to accept these additional risks as part of my/our child's participation in the program.

I/we understand that the School District of Newberry County provides a supplemental, secondary, full excess benefit plan and may not cover all medical expenses, through ADL Risk Services, LLC. Injuries must be reported to a school representative in a timely manner, so that a Student Accident Form (SAF) may be completed by the school.

I/we understand if the student/athlete is injured during an athletic related event, no matter the insurance type, it is the responsibility of the parent/guardian to submit all claims/SAF to ADL. Parents should NOT rely on others to ensure that the SAF is submitted, they should submit the SAF themselves and keep a copy. The remaining balance for medical care will be our responsibility, not the responsibility of the School District of Newberry County, or an individual school/athletic department.

_____ _____

Date Signature of Student Athlete

_____ _____

Date Signature of Parent/Guardian

# Parent Permission & Acknowledgment of Risk for Son or Daughter to Participate in Athletics

**Name (please print)**_____

As a parent or legal guardian of the above named student-athlete, I give 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, 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 do 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.

Signature of Athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Personal Physician: _____

**Emergency Contact**

Name: _____

Relationship: _____

Phone Number(s): _____

_____

# Parent and Student Eligibility Waiver

Student-Athlete Name (please print) _____

I understand and agree to abide by the procedures in the South Carolina High School League (SCHSL) By-Laws. To enable the SCHSL to determine the herein-named student's eligibility to participate in interscholastic athletics in the SCHSL member school, I consent to the release of any and all portions of school record files to SCHSL, of the herein-named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work in progress and/or completed, grades received, and attendance data.

Signature of Athlete _____ Date _____

Signature of Parent _____ Date _____