

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		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.			
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 Health 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 QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Does anyone in your family have 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: _____

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: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin - 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

Parent's Permission & Acknowledgement 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 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: _____

BON SECOURS ST. FRANCIS HEALTH SYSTEM, INC.
CERTIFIED ATHLETIC TRAINING SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____, a student at _____ (the "School"), authorize Bon Secours St. Francis Health System, Inc., SFHS staff to provide my child any healthcare services offered by SFHS Certified Athletic Training Services and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of student athletes, SFHS will provide an athletic trainer to provide on-site treatment and consultation to students at the School. These services will be overseen by a physician serving as Medical Director for Certified Athletic Training Services.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff at SFHS Certified Athletic Training Services to arrange for such care, including appropriate transportation. I understand that SFHS Certified Athletic Training Services staff will contact me as soon as possible in the event my child has an urgent or emergency condition.

I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the Certified Athletic Training Services program. I understand that I may contact the trainer assigned to the School or the Medical Director for Certified Athletic Training Services to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by SFHS staff of information about my child's medical condition obtained through Certified Athletic Training Services to coaches and other employees or agents of the School.

I understand that I will not be charged for services rendered on-site by the trainer assigned to the School, but that I or my insurance carrier will be charged for services rendered by other healthcare providers. I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize SFHS to submit claims for services rendered to my child and assign to SFHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SFHS Certified Athletic Training Services, I hereby release Bon Secours St. Francis Health System, its trustees, officers, employees, and agents from and against any claim, liability, cause of action or other expense arising out of the services provided by SFHS Certified Athletic Training Services.

I have read and understand the above information and consent to my child's participation in SFHS Certified Athletic Training Services.

Name of Parent (of minor patient), or
Legal Guardian (please print)

Name of Student (please print)

Signature of Parent (of minor patient), or
Legal Guardian

Relationship to Student (please print)

Date

Emergency Contact Names

Telephone Numbers

Day _____ Night _____

Day _____ Night _____

Bon Secours St. Francis Health System, Inc.
St. Francis Sports Medicine

Name _____ DOB _____

SSN _____ Phone # _____ Cell # _____

Grade _____ Sport(s) _____

Address _____

Mother _____ Work # _____

Home # _____ E-mail _____

Father _____ Work # _____

Home # _____ E-mail _____

Insurance Carrier _____

Emergency Contact _____

Phone #'s _____

Yes/ No

 Does your child have any of the following? (check appropriate box and list details)

- | | | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Medical Alert Allergies _____ |
| ☐ | ☐ | Allergic to any medication(s) _____ |
| ☐ | ☐ | Asthma _____ Do you have an Inhaler? _____ |
| ☐ | ☐ | Heart Condition _____ |
| ☐ | ☐ | Vision loss _____ |
| ☐ | ☐ | Epilepsy _____ |
| ☐ | ☐ | Diabetes _____ |
| ☐ | ☐ | Kidney condition _____ |
| ☐ | ☐ | Hearing loss _____ |
| ☐ | ☐ | Severe headaches _____ |
| ☐ | ☐ | Other _____ |

Additional medical information:

Previous injuries/surgeries (month/year)? _____

Date of last tetanus booster: _____

Is your child on any medication that is taken on a regular basis? (List) _____

Does your family have a primary care physician? (Name/ phone#) _____

Does your family have an orthopedic MD? _____

My child may take any over-the-counter medication such as Tylenol®/Advil® ☐ yes ☐ no
Specific _____

Parent/Guardian Signature _____ **Date** _____

EXHIBIT C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization is designed to satisfy the Federal Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Patient's Name: _____ (the "Patient")

Health Care Entity: St. Francis Hospital, Inc. and Bon Secours Medical Group Greenville Specialty Care, LLC (collectively, "Bon Secours").

Person, Agency, or Health Care Entity to Whom Disclosure is to be Made: WREN HIGH SCHOOL ("School").

Information or Health Records to be Disclosed: Any information relating to the Patient's medical condition and status in connection with any Services provided by Bon Secours' employed or otherwise retained Certified Athletic Trainers (the "Trainer") or other provider to Patient in connection with Patient's participation in a school athletic program associated with a primary or secondary school operated by the School.

Purpose of Disclosure or at the Request of the Individual: At the Patient's request, Bon Secours will provide the School and/or its designees with information related to Trainer's or other Bon Secours providers treatment of the Patient in connection with the Services provided by Bon Secours personnel. Patient acknowledges, agrees to and authorizes the disclosure of the protected health information about Patient in connection with Patient's participation in a School's athletic programs.

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entities for disclosure of confidential health records. I understand that the health care entity may not condition treatment on my willingness to sign this authorization.

I acknowledge and understand that I may revoke this authorization at any time by providing written notice to _____. But I also understand that this authorization may not be revoked to the extent it has been relied upon by Bon Secours in disclosing or the health care entity in redisclosing any information prior to such revocation. *This authorization shall continue to be valid and in effect for two (2) years unless it is revoked in writing in accordance with the procedures described in this paragraph.*

A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of Bon Secours.

A copy of this authorization shall have the same force and effect as the original. A copy of this authorization will be given to me after it is signed.

Signatures on next page.

[SIGNATURE OF PATIENT OR REPRESENTATIVE]

Date

Name of Patient

Date of Birth (mm/dd/yr) of Patient

If signed by a personal representative of the individual, describe the representative's authority to act for the individual: _____
