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

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 _____

HIGH POINT ACADEMY PARENT PERMISSION AND ACKNOWLEDGEMENTS

(Please Print)

Athlete's Name:_____ Preferred Name:_____

Gender:_____ Age:_____ Date of Birth:_____ Grade:_____

Mailing Address:_____

City:_____ State:_____ Zipcode:_____

Parent or Guardian Name:_____ Phone Number:_____

Alternative Number:_____ Email:_____

Parent or Guardian Name:_____ Phone Number:_____

Alternative Number:_____ Email:_____

Emergency Contact:_____ Phone Number:_____

Preferred Hospital:_____

The accompanying policy and informational handouts for each statement can be found on the school's athletic website at: https://highpointacademy.bigteams.com. Please both parent and student initial each statement and sign below.

ACKNOWLEDGEMENT OF RISK:

_____. _____. As a parent or legal guardian of the above named student-athlete, I give permission for their 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. I grant permission to school officials (athletic trainers, nurses, coaches and administration) who are part of athletic injury prevention and treatment, to have access to necessary medical information. I acknowledge that if my student-athlete is treated by a physician for an ailment or injury, outside of a well visit, I will provide documentation that states the condition and return to play recommendations of the physician. I know that the risk of injury to my student-athlete 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.

HIGH POINT ACADEMY CODE OF CONTACT:

_____. _____. As a High Point Academy student-athlete, participating voluntarily in interscholastic athletics, my signature below represents that I understand that I will abide by the High Point Academy's student code of conduct, the school's athletic policies, the coaches team rules and the rules of the South Carolina High School League.

CONCUSSION STATEMENT:

_____. _____. We have received and reviewed the information regarding concussions provided to us by High Point Academy. Our signatures indicate our understanding of concussion and the importance of reporting concussive incidences and symptoms immediately, as well as our assumption of risks regarding concussion in sports-related activities.

Student Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

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