Chattooga High School

Athletic Physical

Student's Name: _____

DOB: _____

Year in School: Fr So Jr Sr

Sport: _____

Parental Consent for Athletic Participation

WARNING: Participation in inter-scholastic athletics includes a risk of injury which may range in severity from minor to long catastrophic injury, including permanent paralysis from the neck down or death. Although serious injuries are not common in supervised athletic programs, it is possible only to minimize, not eliminate the risk. Players have the responsibility to help reduce the chance on injury by obeying all safety rules, reporting all physical equipment daily. By signing this permission from, you, the parent, acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THESE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I hereby give consent for my child to compete in the Chattooga High School Athletic and to travel with their team to any of its local or out of town events. I also authorize the Certified Athletic Trainer to dispense over the counter medication to my child. I verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

In the case of an emergency or accident involving my child requiring immediate medical or surgical attention, I hereby grant permission to obtain the services of physicians or to transport my child to the hospital if necessary. I also grant permission for my child to be treated by the physicians or Certified Athletic Trainer if I am not present.

_____ _____

Signature of Parent/Guardian Date

Insurance Information:

In the event that it is needed this information will be provided to EMS and/or medical staff. Please make sure the information is accurate. **PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.**

Company:_____ Name of Insured:_____

Policy #:_____ Group #:_____

Emergency Contact Informantion:

Primary Contact:

Name:_____

Relationship to Student:_____

Phone#:_____

Alternate Contact:

Name:_____

Relationship to Student:_____

Phone#:_____

Allergies

Please list any **allergies or medical conditions** on the lines provided below along with the type of reaction. Please note that this information is very important. If you do not have any known allergies, please indicate that on the lines below.

_____

_____

_____

_____

Authorization for Medical Treatment

Please READ AND INTIAL EACH item

_____ In the event that my child is injured while participating in interscholastic athletic activities I give consent to FLOYD medical staff to diagnose and treat any injury.

_____ In the event that emergency medical intervention is deemed necessary I give consent to transport my child to higher care.

_____ I give permission for the Certified Athletic Trainer to provide my child with OTC medication if it is deemed necessary.

I further certify that I am the parent, or if no parent is available, the grandparent, or the legal guardian of the child named above and that I not now nor have I ever been adjudicated incompetent in any court of law.

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION

Height: Weight:

BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N

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, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • 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	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

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

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

Address: _____ Phone: _____

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

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ 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. A copy of the physical examination findings are 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 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

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

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: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

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 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 requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART 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 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an 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 practice or game?	☐	☐
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 had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, 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 does 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?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
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 or food groups?	☐	☐
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 "Yes" answers 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: _____