PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Academic Year:_____

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, 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14)

Examination

Height: **Weight:** ☐ Female ☐ Male

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

Medical	Normal	Abnormal Findings
Apperance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph Nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • 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 • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider 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 (specify below)

Pending further evaluation	Reason:
For any sports	Reason:
For certain sports	Explain:

Recommendations:

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians)

Name of physician/clinic (print/type)_____

Address _____ Phone _____

Signature of physician_____ Date _____

All physicals expire at the end of the academic year

PREPARTICIPATION PHYSICAL EVALUATION

Academic Year:_____

HISTORY FORM

Date of Exam:_____ **Name:**_____ **Date of Birth:**_____

Sex:_____ **Age:**_____ **Grade** (*for year of participation*):_____ **School:**_____ **Sport(s):**_____

Medicines and Allergies: List all 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 ongoing medical conditions? If so, please identify below: ___Asthma ___Anemia ___Diabetes ___ 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 our 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: __High Blood Pressure __ Heart Murmur __High Cholesterol __ Heart infection __Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (ex: EKG/ECG, 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 of 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 broke or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, 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 use 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 infection 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 or 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 student athlete_____ Date:_____

Signature of parent/guardian _____ Date:_____

CHARLESTON COUNTY SCHOOL DISCTRICT CONCUSSION MANAGEMENT PROTOCOL

Charleston County SCHOOL DISTRICT excellence is our standard

Concussion Management is one of the most important and evolving parts of the Athletic arena, the Sports Medicine arena and a focal point of current local, state & national legislature. The Roper Saint Francis Sports Medicine team has partnered with the "Clinic of the Carolinas Trauma network" to help with the changing environment of concussion management and ways to improve concussion treatment in our communities. The program will act in accordance to the "Best Practices" Concussion Model as outlined through the CDC and ImPACT concussion management programs. ImPACT is a computerized tool to help access the cognitive functioning of an athlete. These tools are simply a resource and are *not a requirement.* Having a concussion management program at each school and school district is not only expected, but is now a state law. This type of program is most commonly brought to fruition by a Certified Athletic Trainer (which every school in Charleston County currently has), but should consist of and not be limited to: Principal, Athletic Director, Athletic Trainer, Head Coaches and school Nurse. These guidelines will be associated with the new 2013-2014 South Carolina Concussion Management Bill, passed on 6/7/13. Guidelines of Bill A33, R65, H3061 were amended to include the requirement of a district policy.

OUTLINED IS THE BASIC CONCUSSION MANAGEMENT PROTOCOL ACCORDING TO THE CURRENT BEST PRACTICES

The ImPACT program and SCAT3 clinical diagnostic forms will be the basis of the program structure and used to aid in effective, safe and monitored concussion treatment.

1) Baseline Cognitive Testing (each athlete from the recommended sports [football, soccer & lacrosse] will take the ImPACT baseline test prior to the season) 2) Removal from activity *immediately* if concussion is suspected 3) Evaluation/observation (clinical assessment with SCAT3 by the Athletic Trainer) 4) Follow-up Cognitive Testing (ImPACT given again to give a score to compare with baseline) 5) Return to activity: Once athlete is asymptomatic (no symptoms) they will begin **graduated return to play protocol** and MUST BE CLEARED BY A PHYSICIAN **(clearance may be obtained BEFORE the return to play protocol)**

Rest: Athlete should rest until symptom free for 24 hrs i.e. no headache, dizziness, etc

Return to Play protocol:

DAY 1. Athlete should do light activity that increases heart rate to between 50-70% of their max heart rate, this includes stationary bike or brisk walking. The heart rate should stay in between this range for 15 minutes.

DAY 2. Athlete should increase heart rate to above 70%. Include agility drills such as 4 cone drills, carioca, ladder drills, jumping jacks

DAY 3. Sport Specific Non contact drills: Athlete should be included in sport specific drills and weight training should be increased.

DAY 4. Monitored return to activity: Athlete should be watched in contact situations for symptoms to return

DAY 5. Return to Full contact

REMINDERS & SUMMARY: (ALL IN ACCORDANCE WITH STATE CONCUSSION BILL)

-Removal, duration, and return to play is ONLY determined by absence of symptoms -Best practices state that ImPACT testing and the use of clinical SCAT3 diagnostics are the gold standard for concussion management -Every coach must discuss proper form with their designated team (especially in regards to football tackling) to help avoid compromising situations where concussions generally occur -Each parent and student-athlete must be given or have access to concussion information so that they may be educated on current prevention and treatment methods

- CONCUSSION EVALUATION MAY ONLY BE PERFORMED ONLY BY AN ATHLETIC TRAINER, PHYSICIAN OR NURSE PRACTITIONER.

***CLEARANCE BY A PHYSICIAN IS REQUIRED FOR RETURN TO PLAY IF ATHLETE IS REMOVED FROM PLAY DUE TO A CONCUSSION.**

STUDENT NAME: _____

PARENT SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

Charleston County SCHOOL DISTRICT
excellence is our standard

Parental Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Charleston County School District

Note to parents/guardians: As a parent or legal guardian of the student-athlete named below. I give permission for his/her participation in athletic events, physical evaluation for that participation, and permission to travel via transportation provided by the Charleston County School District. 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, athletic 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. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. 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.

Please review the proposed dates of the games in which your child will be participating and fill in the information requested below.

TO BE COMPLETED BY PARENT/GUARDIAN

If you approve of your son / daughter participating in athletics, receiving any treatment deemed necessary for his/ her well being during participation, and permission to make trips affiliated with athletics. Please fill in the necessary information below, sign your name in the space provided, and return this form.

My son / daughter, _____ has my permission to participate in athletics, receive medical treatment deemed necessary, and travel via transportation provided by the Charleston County School District to all away games / events associated with the _____ athletic program for the _____ school year.
Insert School Name Here

Parent/Guardian Name (print):_____

Telephone Number (where you can be reached at the time of the trip(s): _____

Insurance Type _____

Parent/Guardian Signature _____ Date _____

Student-Athlete Signature _____ Date _____

Note: Students will not be permitted to participate in any athletic sports practice/games/and or travel without a signed Parental Permission & Acknowledgement Form on file.

Created by: Secondary Learning Community Athletic Department (10.2.13)