PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the 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 any 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 out 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 ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, 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 or 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 broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a 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 used 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 infectious 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 of 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 athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

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, 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	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • 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

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Athlete/Parent Concussion Statement

PARENTS AND ATHLETE - Check EACH BOX Once Read and Understood

	Parent	Athlete
* I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.	☐	☐
* I have read and understand the CDC Concussion Fact sheet for parents.	☐	☐
* I have read and understand the CDC Concussion Fact sheet for athletes.	☐	☐

After reading the Concussion fact sheet, I am aware of the following information:

	Parent	Athlete
* A concussion is a brain injury that I am responsible for reporting to my athletic trainer, physician, or coach.	☐	☐
* A concussion can affect everyday activities, athletic performance balance, sleep, reaction time, and classroom performance.	☐	☐
* If I suspect a teammate has a concussion I am responsible for reporting the injury to my athletic trainer.	☐	☐
* I will not return to activity on the same day if I have received a blow to the head or body that results in concussion related symptoms.	☐	☐
* Following a concussion the brain needs time to heal. You are much more likely to have another concussion if you return to play prior to your symptoms resolving.	☐	☐
* In rare cases, repeat concussions can cause permanent brain damage or even death.	☐	☐
* I understand that physician clearance, and completion of Return-to-Play Protocol must be completed before an athlete returns to full participation.	☐	☐

Signatures

Student Athlete

Print Name: _____

Signature: _____

Date: _____

Parent / Guardian

Print Name: _____

Signature: _____

Date: _____

My clicking on the Sign & Submit Form button below is my signature and indicates that to the best of my knowledge, my answers and information provided to the above questions are complete and correct. I understand that the information that I have provided on this form may be used for analytical and research purposes. I consent to the access and use of this data by the Oconee 01 School District, PlanetHS, LLC.

I further hereby authorize the possession of my, or my child's/ward's, individually identifiable health information by Oconee 01 School District, PlanetHS, LLC, and the use and disclosure of such information should treatment for illness or injury become necessary. I consent to the transmission and disclosure to the South Carolina High School League and PlanetHS, LLC of all records and personally identifiable information relevant to my, or my child/ward's, athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, Individualized Education Program, age, emergency contact information, discipline, residence and physical fitness.

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

* Name

_____

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.

Signatures

Student Athlete

Print Name: _____

Signature: _____

Date: _____

Parent / Guardian

Print Name: _____

Signature: _____

Date: _____

My clicking on the Sign & Submit Form button below is my signature and indicates that to the best of my knowledge, my answers and information provided to the above questions are complete and correct. I understand that the information that I have provided on this form may be used for analytical and research purposes. I consent to the access and use of this data by the Oconee 01 School District, PlanetHS, LLC.

I further hereby authorize the possession of my, or my child's/ward's, individually identifiable health information by Oconee 01 School District, PlanetHS, LLC, and the use and disclosure of such information should treatment for illness or injury become necessary. I consent to the transmission and disclosure to the South Carolina High School League and PlanetHS, LLC of all records and personally identifiable information relevant to my, or my child/ward's, athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, Individualized Education Program, age, emergency contact information, discipline, residence and physical fitness.

PlaySafe Emergency Info Form

Name On Birth Certificate (Last, First, MI)

Preferred Name

DOB | Grade | Sport(s)

Address

Mother/Guardian | Contact #

Work Contact # | Email

Father/Guardian | Contact #

Work Contact # | Email

Insurance Carrier

Claim/Policy #

Emergency Contact (Non-Parent/Guardian) | Phone #

Primary Care Physician | Phone #

Please list any injuries, allergies, or other medical history that you feel may be important in case of an emergency:

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

My child may take any over-the-counter medication such as Tylenol, Advil, etc. or topical ointments such as Neosporin, hydrocortisone, etc. as needed **Yes** ○ or **No** ○

I grant permission for my son/daughter to practice and play in athletic events for _____ High School. I will not hold the school responsible in any way whatsoever, except where negligence exists. I also grant permission for treatment deemed necessary for a condition arising during participation in the activity, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

Date

Signatures

Student Athlete

Print Name: _____

Signature: _____

Date: _____

Parent / Guardian

Print Name: _____

Signature: _____

Date: _____

My clicking on the Sign & Submit Form button below is my signature and indicates that to the best of my knowledge, my answers and information provided to the above questions are complete and correct. I understand that the information that I have provided on this form may be used for analytical and research purposes. I consent to the access and use of this data by the Oconee 01 School District, PlanetHS, LLC.

I further hereby authorize the possession of my, or my child's/ward's, individually identifiable health information by Oconee 01 School District, PlanetHS, LLC, and the use and disclosure of such information should treatment for illness or injury become necessary. I consent to the transmission and disclosure to the South Carolina High School League and PlanetHS, LLC of all records and personally identifiable information relevant to my, or my child/ward's, athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, Individualized Education Program, age, emergency contact information, discipline, residence and physical fitness.

Protected Health Information Authorization 2018-2019

For Release of Information

School: _____

I hereby authorize any medical provider associated with my school/organization, specifically PlaySafe to use and/or disclose my clearance and health recommendations to the athletic director, coaches, athletic trainers and medical personnel at my school/organization to inform them of my health status for the participation in athletics or activities. I understand that my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the state or federal law.

Athlete's Printed Name: _____

Date:_____ Athlete's Signature if 18 or older: _____

Parent's Printed Name: _____

Date: _____ Parent/Guardian Signature: _____

SDOC Athletic Policy Form

The SDOC Student Athlete Policy is posted on the SDOC Website. Parents should read the policy carefully

_____ I understand that participating in athletics at, for SDOC is a privilege and is not a requirement for graduation. therefore, whether I agree or disagree with all or part of this policy, I understand what is expected of me to be a part of the program

IN ADDITION, MY CHILD AND I HAVE READ THE ATTACHED "PARENT/ATHLETE CONCUSSION INFORMATION SHEET".

Date _____ Sport _____ HEAD COACH _____

Student Name _____ Parent Name _____

EMERGENCY CONTACT INFORMATION

to be completed by parent or guardian

Student Name

First _____ Last _____ MI _____ Sport _____

Date of Birth(m/d/y) _____ Grade in school _____ Telephone #/Contact info. _____

Parent/Guardian Name

First _____ Last _____ MI _____ Emergency contact Name _____

Permanent Address _____ City _____ Zip _____ Emergency Contact # _____

Primary Insurance Company _____ Policy claim Number _____

Signatures

Student Athlete

Print Name: _____

Signature: _____

Date: _____

Parent / Guardian

Print Name: _____

Signature: _____

Date: _____

My clicking on the Sign & Submit Form button below is my signature and indicates that to the best of my knowledge, my answers and information provided to the above questions are complete and correct. I understand that the information that I have provided on this form may be used for analytical and research purposes. I consent to the access and use of this data by the Oconee 01 School District, PlanetHS, LLC.

I further hereby authorize the possession of my, or my child's/ward's, individually identifiable health information by Oconee 01 School District, PlanetHS, LLC, and the use and disclosure of such information should treatment for illness or injury become necessary. I consent to the transmission and disclosure to the South Carolina High School League and PlanetHS, LLC of all records and personally identifiable information relevant to my, or my child/ward's, athletic eligibility including, but not limited to, records relating to enrollment and attendance, academic standing, Individualized Education Program, age, emergency contact information, discipline, residence and physical fitness.