

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	Medical Questions			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?					16. Do you cough, wheeze, or have difficulty breathing during or after exercise?				
2. Has a provider ever denied or restricted your participation in sports for any reason?					17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?				
3. Do you have any ongoing medical issues or recent illness?					18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				
Heart Health Questions About You				Yes	No	19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?					20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?					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?				
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?					22. Have you ever become ill while exercising in the heat?				
7. Has a doctor ever told you that you have any heart problems?					23. Do you or someone in your family have sickle cell trait or disease?				
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.					24. Have you ever had or do you have any problems with your eyes or vision?				
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?					25. Do you worry about your weight?				
10. Have you ever had a seizure?					26. Are you trying to or has anyone recommended that you gain or lose weight?				
Health Questions About Your Family				Yes	No	27. Are you on a special Diet or do you avoid certain types of foods?			
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)?					28. Have you ever had an eating disorder?				
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)?					Females Only				
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?					29. Have you ever had a menstrual period?				
Bone and Joint Questions				Yes	No	30. How old were you when you had your first menstrual period?			
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?					31. When was your most recent menstrual period?				
15. Do you have a bone, muscle, ligament or joint injury that bothers you?					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 _____

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgement.

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: _____

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. | <input type="checkbox"/> | <input type="checkbox"/> |
| * I have read and understand the CDC Concussion Fact sheet for parents. | <input type="checkbox"/> | <input type="checkbox"/> |
| * I have read and understand the CDC Concussion Fact sheet for athletes. | <input type="checkbox"/> | <input type="checkbox"/> |

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. | <input type="checkbox"/> | <input type="checkbox"/> |
| * A concussion can affect everyday activities, athletic performance balance, sleep, reaction time, and classroom performance. | <input type="checkbox"/> | <input type="checkbox"/> |
| * If I suspect a teammate has a concussion I am responsible for reporting the injury to my athletic trainer. | <input type="checkbox"/> | <input type="checkbox"/> |
| * 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| * 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| * In rare cases, repeat concussions can cause permanent brain damage or even death. | <input type="checkbox"/> | <input type="checkbox"/> |
| * I understand that physician clearance, and completion of Return-to-Play Protocol must be completed before an athlete returns to full participation. | <input type="checkbox"/> | <input type="checkbox"/> |

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

2020-2021

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.