# PLEASE RETURN FORMS TO THE SCHOOL OFFICE AT SCPS ON/BEFORE Monday, April 24th, 2017 IF PARTICIPATING IN THIS SCREENING

Dear Parent / Guardian: March 8, 2017

Enclosed you will find the athletic pre-participation screening packet that is required of all students trying out for and/or participating in a school sport during the 2017-2018 school year. If your child is interested in playing a school sport next year, or *participating in an Upper School PE class or Marching Band*, we strongly recommend that you take advantage of the upcoming Pre-Participation Screening (PPS) that will be taking place on Wednesday, April 26th, 2017. **The screening will begin at 2:00 for the lower school, followed by the upper school and middle school. These screenings will occur in the Eckburg Gymnasium.** The PPS is being jointly conducted by Memorial Sports Medicine, Memorial Family Practice, Chatham Orthopedics, and the SCPS athletic department. The cost of the screening is **$15.00** cash or check made payable to SCPS. All funds collected from the PPS will go directly to your school's athletic department to help defray costs for athletic training supplies. This screening will be valid through the end of the 2017-2018 school year, and will be kept on file at the school.

If your child will be participating in the PPS, please completely fill out the Emergency Contact & Insurance Information, Permission and Medical Release Form, SCPS Medication Consent Form, SCPS permission form, and Pre-Participation Physical Evaluation-History portion (page 9), as well as the first line of pages 10-11. It is extremely important that this packet is completed, signed by you and the student-athlete; and **returned to the Athletic Trainer or School Office by Monday, April 24th**. This will expedite your child's PPS process and ensure that s/he gets through the screening in a timely fashion. Incomplete information or missing signatures could *disqualify* or *delay* your child from our screening process. This means that you will have to arrange for your child to receive a PPS/Physical by your own means.

If your child is unable to attend the screening on April 26th, 2017, you may have your child's physical completed by your personal physician. Please note that pages 1-8 need to be completed by you and pages 9-11 must be completed and signed by a Licensed Medical Physician or Doctor of Osteopathic Medicine. Once the packet is completed by the physician, please return it to school office so that it can be filed properly. All physical packets are due **before** the first day of practice of your child's sport.

Be aware that the PPS on April 26th is not the same as a regular physical exam administered by your family physician. It is a screening to ensure that your child is medically eligible for participation in accordance to Georgia High School Association guidelines. Memorial Sports Medicine recommends that every child receive a regular physical exam from his/her primary care physician to ensure general good health. ***If your child currently takes a prescription medication or has a medical condition, please have the treating physician send a clearance note stating your child is able to participate in athletics while under their care.*** Furthermore, if your child has any of the following conditions, they **MAY NOT** be cleared to participate in athletic activities until they receive a clearance letter from a primary care physician:

- Asthma, any diagnosed heart conditions, unusual or elevated Blood Pressure readings,
- History of diabetes or Sickle Cell Trait/Anemia
- History of multiple concussions
- Athletes with certain prescription medications
- Any medical conditions in need of further medical review

We strongly encourage every student who is slightly interested in trying out for any sport to take advantage of this opportunity. If you have any questions about any part of the screening process or about athletic physicals in general, please feel free to contact Ansley Hendrick, MS, LAT, ATC at **ahendrick@savcps.com**. Thank you for your cooperation in this matter and we look forward to working with your student-athlete this coming school year.

Sincerely,

Ansley Hendrick, MS, LAT, ATC
Memorial Sports Medicine Athletic Trainer

Savannah Christian Preparatory Athletic Administration

School Year 2017-2018

Memorial Sports Medicine Experience Excellence.

# EMERGENCY CONTACT & INSURANCE INFORMATION

**Student's Name (Legal)**_____,____ _____, _____
LAST FIRST MI

**Social Security #**_____-_____-_____ **D.O.B**_____/_____/_____ **2016-17 Grade Level:** _____

**Address:** _____, **GA** _____
STREET CITY ZIP

**Student's Home Phone #:** _____ **Student's Cell Phone #:** _____

**Child Lives With:** _____ Father _____Mother ____Both _____ Other: _____

**Father/Guardian's Name:** _____ **Home Phone #(**_____**)**_____**-**_____

*Father/Guardian's Employer:* _____

*Father/Guardian's Cell Phone # (*_____*)*_____*-*_____ *Work Phone # (*_____*)*_____*-*_____*ext*_____

**Mother/Guardian's Name:**_____ **Home Phone#(**_____**)**_____**-**_____

*Mother's Employer:*_____

*Mother/Guardian's Cell Phone # (*_____*)*_____*-*_____ *Work Phone # (*_____*)*_____*-*_____*ext*_____

**Parent/Guardian contact e-mail address:** _____

**Emergency Contact & Relationship (must be 21 or older):** _____

*Contact Home Phone # (*_____*)*_____*-*_____ *Contact Cell Phone # (*_____*)* _____*-* _____

**Primary Physician:** _____ **Office Phone # (**_____**)**_____**-**_____**ext**_____

## INSURANCE INFORMATION

**Primary Insurance Co:** _____ **Name of Policy Holder:** _____

**Policy #:** _____ **Group #:** _____

**Insurance Co. Phone # (**_____**)**_____**-**_____**ext** _____

## **PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD**

**Medical Conditions:** _____
**Allergies:** _____
**Medications & Condition:** _____

### PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE

*I give permission for representatives of Savannah Christian Preparatory School to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation and treatment by certified athletic trainers at away competitions.

**Print Parent Name:**_____ **Parent Signature:** _____

# *PLEASE ATTACH COPY

# (FRONT/BACK) OF

# STUDENT'S

# INSURANCE CARD*

Memorial Sports Medicine Experience Excellence.

School Year 2017-2018

# PERMISSION & MEDICAL RECORD RELEASE FORM

**Student's Name:** _____

**Last** **First** **M.I.**

## ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Savannah Christian Preparatory School, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Savannah Christian Preparatory School activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Savannah Christian Preparatory School, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to Memorial Health and Memorial Sports Medicine to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Health and/or the Savannah Christian Preparatory School financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that **Football** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, Cheerleading, Lacrosse, Soccer, Softball, and Volleyball** which involve greater risk of injury than **non-contact sports: Bowling, Cross Country, Equestrian, Golf, Rowing, Swimming, Track & Field and Tennis.**

_____ ___/____/_____ _____ ___/____/____

Student's Signature Date Parent /Guardian Signature Date

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

**General Disclosure:**

I hereby authorize Memorial Health and/or Memorial Sports Medicine Medical Personnel to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2016-2017 school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Health and/or Memorial Sports Medicine discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

_____ ___/___/____ _____ ___/____/_____

Student's Signature Date Parent/Guardian Signature Date

# GHSA: HEAT & HUMIDITY POLICY

## Heat and Humidity Awareness:

GHSA has a statewide practice policy for extremely high heat and humidity that list guidelines for monitoring the heat during sports that occur in the warmer months. This includes practices, games, and voluntary conditioning.

**GUIDELINES FOR HYDRATION AND REST BREAKS:**

- Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity.
- For football, helmets should be removed during rest time.
- The site of rest should be a "cooling zone" and not in direct sunlight.
- When the WBGT reading is over 86:
    - Ice towels and spay bottles filled with ice water should be available at the "cooling zone" to aid the cooling process
    - Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

Please refer to BY-LAW 2.67-GHSA Practice Policy for Heat and Humidity for more details:
http://www.ghsa.net/sites/default/files/documents/sports-medicine/HeatPolicy2013.pdf

It is recommended that all guidelines be followed in such a way that the best interests of our students be made our number one priority. It is also recommended that coaches constantly teach our students about proper hydration throughout each day. It is important that student-athletes be allowed to carry water with them during the day and hydrate themselves, on days of practices and games, while the weather has the possibility of reaching critical levels in relation to the heat and humidity.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

_____ _____

***Student Athlete Signature*** ***Date***

_____ _____

***Parent/Guardian Signature*** ***Date***

Memorial Sports Medicine Experience Excellence.

# Memorial Sports Medicine
# CONCUSSION AWARENESS INFORMATION AND GUIDELINES

The purpose for this document is to provide crucial information for student-athletes and parents/legal guardians. This form must be signed by both the athlete and parent/legal guardian prior to tryouts, workouts or other forms of participation.

## Concussion Awareness Information:

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short term or long-term). A concussion is a brain injury that results in temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

**COMMON SIGNS OF A CONCUSSION:**

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

Please refer to BY-LAW 2.68-GHSA Concussion policy for more details:
http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion_Form.pdf

## Student-Athlete Concussion/Head Injury Guidelines:

I affirm that:

- It is my responsibility as a student athlete or as the parent/legal guardian of a student athlete to report all injuries and illnesses to my Athletic Trainer or Memorial Sports Medicine representative.
- I have fully disclosed, in writing, all prior head injury related events and medical conditions and will disclose any future conditions to my Athletic Trainer or Memorial Sports Medicine representative.
- I understand the importance of and will immediately report any and all signs and symptoms of a head injury, including concussion, to the Memorial Sports Medicine representative or my Head Coach.
- I understand there is the possibility that participation in any sport may result in a head injury and/or concussion.
- I will be provided with the Heads Up-Concussion Fact Sheet / NCAA Concussion Fact sheet for student-athletes.
- If there are questions or I wish to discuss any areas and issues that are not clear to me concerning head injuries, I have the contact information of a Memorial Sports Medicine Athletic Trainer.
- I acknowledge that no piece of equipment can prevent injury/illness/concussion. Specifically, helmets or soccer headbands may help to prevent catastrophic head injury but do not significantly reduce the risk of a head injury, including concussion. I understand that it is my responsibility to wear (or to ensure the student-athlete wears) any equipment issued to me (or the student-athlete) in the appropriate manner.
- I agree to read and abide by all warning labels on any equipment before use.
- I have read and reviewed the following statement released by the National Operating Committee on Standards for Athletic Equipment (NOCSAE)
    - **Helmet Warning Statement** *(For those student-athletes who will play football at any level):*
        - **"Keep your head up. Do not use this helmet to butt, ram, or spear an opposing player with any part of this helmet or faceguard. This is in violation of football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent. No helmet can prevent all head or neck injuries a player might receive while participating in football."**

**BY SIGNING I AFFIRM THAT I HAVE READ THIS FORM AND I UNDERSTAND ALL THE FACTS PRESENTED IN IT.**

_____ _____

***Student Athlete Signature*** ***Date***

_____ _____

***Parent/Guardian Signature*** ***Date***

# Savannah Christian Preparatory School
# Medication Consent Form

Permission is hereby granted to the Head Athletic Trainer to dispense the following over-the-counter medications to my child: (please check chosen medications)

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil)
_____ Naproxen Sodium (Aleve)
_____ Midol
_____ Migraine Relief
_____ Electrolytes (Medi-Lyte)
_____ Electrolytes (Heat Guard)
_____ Nasal Relief Spray
_____ Antacid Tablets
_____ Pepto-Bismol
_____ Anti-histamine (Dipenhydramine HCL)
_____ Sore Throat Spray
_____ Cough Drops

**OR**

_____ I **DO NOT** wish any medications to be given to my child

Current Medical Concerns: (allergies, athma, etc) _____

Current Medications your child is taking: _____

- If your child is currently taking any medications prescribed by a physician, please go ahead and obtain a written note from the MD stating that your child is prescribed the medication and is clear to play sports on such medication. Please attach this to this form. If you do not have this prior to the physical, your child may be disqualified until the information can be submitted.

_____ _____
Signature of Parent or Guardian Date

Phone: (Home)_____ (other) _____

Family Physician: _____ Phone_____
Specialist:_____Phone:_____

# SAVANNAH CHRISTIAN PREPARATORY SCHOOL
## ATHLETIC DEPARTMENT

1599 Chatham Pkwy
P.O. Box 2848
Savannah, GA 31402-2848

(912) 234-1653
(912) 234-0491 Fax

## PARENTAL PERMISSION AND RELEASE FORM

Student's Name: _____

Homeroom Grade & Section: _____

We hereby give permission for our child to participate in the athletic/extracurricular activity programs of Savannah Christian Preparatory School.

We understand that injuries may occur while participating in these programs and we will not hold Savannah Christian nor its coaches, faculty or staff liable for any expenses thereof.

We also understand that SCPS provides student accident insurance at no cost to us and that this insurance is a SUPPLEMENTAL PLAN and is subject to a DEDUCTIBLE, LIMITATIONS AND EXCLUSIONS which may result in balances owed by the parents. We further understand that this supplemental policy is designed to complement our family coverage (private or group policy), and that a copy of its provision will be available from the school office.

Parent's Signature: _____

Parent's Signature: _____

Student's Signature: _____

Date: _____

2017-2018

# 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 _____

# PREPARTICIPATION PHYSICAL EVALUATION
# PHYSICAL EXAMINATION FORM

**2017-2018**

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<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• 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<br>• 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. 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 (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

# PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

**2017-2018**

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ 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. 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 (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

**EMERGENCY INFORMATION**

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____