ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

| lame | | | | | | | |
|---|---|---|------------|-----------|--|--------|----------|
| ex | Age | Grade S | School | | Sport(s) | | |
| Medicine | s and Allergies: | Please list all of the prescription and ov | er-the-co | unter n | nedicines and supplements (herbal and nutritional) that you are currently | taking | |
| | | 1 | | | | E (3 | |
| Do you ha ☐ Medic | ve any allergies? | ☐ Yes ☐ No If yes, please in ☐ Pollens | lentify sp | ecific al | llergy below. □ Food □ Stinging Insects | | 5 |
| xplain "Ye | s" answers belo | v. Circle questions you don't know the | nswers t | to. | | | |
| GENERAL C | UESTIONS | | Yes | No | MEDICAL QUESTIONS | Yes | N |
| 1. Has a d | | r restricted your participation in sports for | | | 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | Trains | |
| below: | □ Asthma □ / | nedical conditions? If so, please identify Anemia | | i Ger | 27. Have you ever used an inhaler or taken asthma medicine? 28. Is there anyone in your family who has asthma? | | |
| Other: 3. Have yo | | ght in the hospital? | | | 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | 70.50 | |
| 4. Have yo | u ever had surgery | ? | | | 30. Do you have groin pain or a painful bulge or hernia in the groin area? | 1 44 | |
| | LTH QUESTIONS / | | Yes | No | 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| | u ever passed out of exercise? | or nearly passed out DURING or | | | 32. Do you have any rashes, pressure sores, or other skin problems? | | 1, |
| | | ort, pain, tightness, or pressure in your | +- | | 33. Have you had a herpes or MRSA skin infection? | "R". L | - |
| | uring exercise? | ort, pain, lightness, or pressure in your | | | 34. Have you ever had a head injury or concussion? | | _ |
| 7. Does yo | ur heart ever race | or skip beats (irregular beats) during exercise | ? | | 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| | | that you have any heart problems? If so, | | | 36. Do you have a history of seizure disorder? | | \vdash |
| | ll that apply: h blood pressure | ☐ A heart murmur | | | 37. Do you have headaches with exercise? | | \vdash |
| | h cholesterol | ☐ A heart infection | | | 38. Have you ever had numbness, tingling, or weakness in your arms or | | |
| | vasaki disease | Other: | | - | legs after being hit or falling? | | |
| | octor ever ordered a diogram) | a test for your heart? (For example, ECG/EKG, | | | 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| | | eel more short of breath than expected | | | 40. Have you ever become ill while exercising in the heat? | | |
| | xercise? u ever had an unex | Popura politica | - | | 41. Do you get frequent muscle cramps when exercising? | | |
| | | ort of breath more quickly than your friends | | | 42. Do you or someone in your family have sickle cell trait or disease? | 151 | |
| | xercise? | or or breath more quickly than your ments | | | 43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries? | | \vdash |
| IEART HEA | LTH QUESTIONS A | BOUT YOUR FAMILY | Yes | No | 44. Have you had any eye injuries? 45. Do you wear glasses or contact lenses? | | - |
| | | relative died of heart problems or had an | | | 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| | | sudden death before age 50 (including accident, or sudden infant death syndrome)? | | | 47. Do you worry about your weight? | | |
| M. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10 | | have hypertrophic cardiomyopathy, Marfan | 1 | | 48. Are you trying to or has anyone recommended that you gain or | | |
| syndron | ne, arrhythmogenic | right ventricular cardiomyopathy, long QT | | | lose weight? | . 3 | |
| | ne, short QT syndro phic ventricular tac | me, Brugada syndrome, or catecholaminergio hycardia? | | | 49. Are you on a special diet or do you avoid certain types of foods? | | |
| | | have a heart problem, pacemaker, or | | | 50. Have you ever had an eating disorder? | | 11 |
| | ed defibrillator? | That's a risear problem, passinanel, si | | | 51. Do you have any concerns that you would like to discuss with a doctor? | | 4 |
| | | nad unexplained fainting, unexplained | | | FEMALES ONLY | | |
| | , or near drowning: | | Ves | N. | 52. Have you ever had a menstrual period? | | |
| | | y to a bone, muscle, ligament, or tendon | Yes | No | 53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months? | | |
| | | ractice or a game? | - | - | | 1,000 | - |
| 8. Have you | u ever had any brol | ken or fractured bones or dislocated joints? | | | Explain "yes" answers here | | |
| | | that required x-rays, MRI, CT scan, a cast, or crutches? | | - | 7 | | |
| 20. Have you | u ever had a stress | fracture? | | | | | |
| instabilit | y or atlantoaxial in | at you have or have you had an x-ray for neck stability? (Down syndrome or dwarfism) | | | | | |
| 2. Do you r | egularly use a brac | e, orthotics, or other assistive device? | | | | | _ |
| 3. Do you h | ave a bone, muscl | e, or joint injury that bothers you? | | | | | |
| | | ne painful, swollen, feel warm, or look red? | | | | | _ |
| | | juvenile arthritis or connective tissue disease | . 1 | | | | |

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■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

| Date of Exa | ım | | | | | |
|---------------|---|--------------------------------|--|---------------|--------------|----|
| Name | | | | Date of birth | | |
| | Ann | Crada | Cabaal | | | |
| Sex | Age | Grade | School | Sport(s) | | |
| 1. Type of | disability | | | | | |
| 2. Date of | | | | | | |
| 3. Classific | cation (if available) | 6) | | | | |
| | Parallel Street | ease, accident/trauma, other |) | | | |
| | sports you are intere | | • | | | |
| | | | | | Yes | No |
| 6. Do you | regularly use a brace | , assistive device, or prosthe | tic? | | | |
| | | e or assistive device for spor | | | | |
| | | ssure sores, or any other ski | | 8 | | |
| 9. Do you | have a hearing loss? | Do you use a hearing aid? | | | | |
| 10. Do you | have a visual impaire | nent? | | - 20 | | |
| 11. Do you | use any special devi | ces for bowel or bladder fund | tion? | | | |
| 12. Do you | have burning or disc | omfort when urinating? | | | | |
| 13. Have yo | ou had autonomic dy | reflexia? | | | | |
| 14. Have yo | ou ever been diagnos | ed with a heat-related (hype | rthermia) or cold-related (hypothermia) illne | ss? | 1 | |
| 15. Do you | have muscle spastic | ty? | | | | |
| 16. Do you | have frequent seizur | es that cannot be controlled | by medication? | | | |
| Explain "yes | s" answers here | | | | | |
| , | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Diagon india | ata if you have over | had any of the following. | | | | |
| Ticase muic | ate ii you nave evei | nad any or the following. | | | Yes | No |
| Atlantoaxial | Inetability | | | | 163 | No |
| | ation for atlantoaxial | netahility | *1 | | | |
| | oints (more than one | | | | — | |
| Easy bleeding | | | | | | |
| Enlarged sp | | | | | | , |
| Hepatitis | 10011 | | | | | |
| | or osteoporosis | | | | | |
| | ntrolling bowel | | | | | |
| | ntrolling bladder | | | | | |
| | or tingling in arms or | hands | | | | |
| | or tingling in legs or f | 7979 | В | | | |
| | n arms or hands | 7.5% | | | | |
| | n legs or feet | | | | | |
| | nge in coordination | | | | | |
| Recent char | nge in ability to walk | | | | | |
| Spina bifida | 1 | | | | | |
| Latex allerg | у | | | | | |
| Explain "yes | answers here | | | b 1 | | |
| | | | | | | |
| | | | | | 100 | |
| | | | | | V. | |
| | | | , | | V). | |
| | | | , | | | |
| | | | | 3 | = | |
| I hereby stat | te that, to the best o | f my knowledge, my answ | ers to the above questions are complete | and correct. | | |
| I hereby stat | • | f my knowledge, my answ | ers to the above questions are complete Signature of parent/guardian | and correct. | Date | , |

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

| Name | TO VICE OF THE | 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 supple have you ever taken any supplements to help you gain or lose weight or imp Do you wear a seat belt, use a helmet, and use condoms? Consider reviewing questions on cardiovascular symptoms (questions 5–14). | | |
| EXAMINATION | | Section 1997 The Sectio |
| Height Weight | ☐ Male ☐ Female | |
| BP / (/) Pulse | Vision R 20/ | L 20/ Corrected PY N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnoda arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | ctyly, | |
| Eyes/ears/nose/throat Pupils equal Hearing | | The second second |
| Lymph nodes | | |
| Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI) | | |
| Pulses | | THE PROPERTY OF THE PERSON OF |
| 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 | | 050 0 |
| Wrist/hand/fingers Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional Duck-walk, single leg hop | | |
| *Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. *Consider GU exam If in private setting, Having third party present is recommended. *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 | | |
| — You ally opolito | | |
| | automie 2.15, me aut. | |
| Reason | to the second second | 12 MINESTER BY CARRA SEC OF EMPLOYS WORTH COLING S |
| Recommendations | ************************************** | A COMPANY OF THE SECOND MINISTER COMPANY OF THE PROPERTY OF TH |
| I have examined the above-named student and completed the preparticipation ph participate in the sport(s) as outlined above. A copy of the physical exam is on rec arise after the athlete has been cleared for participation, a physician may rescind to to the athlete (and parents/guardians). | ord in my office and can be ma | ade available to the school at the request of the parents. If conditions |
| Name of physician, advanced practice nurse (APN), physician assistant (PA) (prin | t/type) | Date of exam |
| Address | | 200 |
| Signature of physician, APN, PA | -1,41 | origina in anticontrates and only and a contrates. |

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

| Name | Sex M F Age | Date of birth |
|---|--------------------------|---------------|
| ☐ Cleared for all sports without restriction | | |
| ☐ Cleared for all sports without restriction with recommendations for further eva | luation or treatment for | |
| | | |
| ☐ Not cleared | | |
| ☐ Pending further evaluation | | |
| ☐ For any sports | | |
| ☐ For certain sports | | |
| Reason | | |
| Recommendations | | |
| | 2 | |
| | | 6 - |
| | | |
| | | |
| | | |
| EMERGENCY INFORMATION | | |
| | | |
| Allergies | | |
| | P | |
| | <u>.</u> | |
| | | |
| | | |
| | | |
| Other information | | - |
| | | |
| | | |
| | | |
| HOD OFFICE CTAMP | SCHOOL PHYSICIAN: | |
| HCP OFFICE STAMP | | |
| | Reviewed on | (Date) |
| | Approved No | |
| | Signature | |
| | Olgridiane | |
| I have examined the above-named student and completed the prepa clinical contraindications to practice and participate in the sport(s) | | |
| and can be made available to the school at the request of the paren the physician may rescind the clearance until the problem is resolve (and parents/guardians). | | |
| Name of physician advanced exection pures (ADN) attraction and (DA) | | Date |
| Name of physician, advanced practice nurse (APN), physician assistant (PA) | | |
| Address | | |
| Signature of physician, APN, PA | | |
| Completed Cardiac Assessment Professional Development Module | | |
| Date Signature | | |