Player's Name: _____

DADE COUNTY SCHOOLS PREPARTICIPATION ATHLETICS INFORMATION

■ 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: _____

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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 ☐ InfectionsOther: _____		
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?

■ Preparticipation Physical Evaluation THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

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

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

Yes **No**

6. Do you regularly use a brace, assistive device, or prosthetic?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	YES	NO
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		

Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

■ 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		

■ 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 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/Medications _____

PARENTAL CONSENT and AUTHORIZATION

Although participation in supervised interscholastic activities may be one of the least hazardous in which your son/daughter will engage in or out of school, by its nature, participation in such activities includes a risk of injury which may range in severity from minor to long-term catastrophic. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate this risk. Participants can and have the responsibility to help reduce the chance of injury by obeying all safety rules, reporting all physical problems to appropriate school personnel, following a conditioning program and inspecting equipment daily.

I also understand that per *The Georgia High School Association*, a **Pre-participation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Dade County School System. This medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations.

In case of emergency or accident during any school activity involving my child, who in the opinion of school authorities present, requires immediate medical or surgical attention, I hereby grant permission to said authorities to obtain the services of a physician or to transport said child to the hospital. I hereby grant permission also, to said physicians, to treat said condition. Permission is also granted to the coach or athletic trainer to provide the needed emergency treatment to the athlete prior to his/her admission to medical facilities.

By signing below, I certify all information contained in this form is complete and accurate. I certify that my child may compete in school athletics in Dade County Schools, and to accompany any school team of which the student is a member on any school-sponsored trips. I also agree to release the Dade County School System, its Athletic Department, its employees, agents, representatives, coaches, and volunteers from any and all liability, actions, causes of actions, debts, claims, or demands of any activities related to the sport/s participated in.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE **STUDENT/ATHLETE** **DATE**

Dade County Schools
Athletics
Proof of Insurance/Parental Consent

INSURANCE INFORMATION

Please initial one of the following statements regarding insurance coverage for your son/daughter, provide the necessary information and sign below.

_____My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletics.

Company Providing Insurance_____

Name of Insured_____

Policy Number_____

_____I wish to purchase school insurance (Markel Insurance Company), which will cover my child for athletics at Dade County Schools.