

Pre Physical - Feb 21 - Fri
Physical - March 5
Cost \$15.00

COFFEE COUNTY SCHOOLS
NEW BROCKTON, KINSTON, ZION CHAPEL

LIBERTY CITY SCHOOLS

MEDICAL SCREENING EXAMINATION FORM

DATE _____ School or Organization _____

Name _____
Last First Middle

Address _____
Street

City State Zip

Parents e-mail address _____

Phone (_____) _____ S.S. # _____

Parents Work Phone (_____) _____

Date of Birth _____ Age _____ Sex _____

Name of Family Physician _____

CONSENT FOR SCREENING: The undersigned agrees to submit to a medical screening examination for athlete participation. I understand that this is a screening examination designed to identify common conditions or infirmities that would limit or prevent participation in athletic activities. This examination is not intended to be comprehensive and may not detect some types of latent or hidden medical conditions.

This is to certify that I have read and understand the above information and have given my permission and consent to the screening for athletic participation.

I hereby state that, to the best of my knowledge, the answers I have given on the medical examination are true and correct.

Student Athlete's Signature Date

Parent's Signature Date



**SOUTHERN BONE &
JOINT SPECIALISTS**

**RELEASE OF MEDICAL INFORMATION
& ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

In order to protect the privacy and security of individual health information, Southern Bone & Joint Specialists is complying with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule. Our **Notice of Privacy Practices** is included in this packet.

Be sure to sign and return this form along with your physical form in order for your physical exam to be done.

RELEASE OF MEDICAL INFORMATION:

I _____ understand that participation in a sports program is a privilege. Along with the participation, there is adherent danger and possibilities of injury. In the event of an injury or any recognition of abnormalities found within the physical exam, I authorize Southern Bone & Joint Specialists to discuss my condition with other medical professionals involved with the treatment of my condition including referring physicians. I understand that my condition may also need to be discussed with my school officials.

Communication from Southern Bone & Joint Specialists will be with the student, their family or guardian and if necessary any of the following: School Athletic Director, Head Sports Coach, Assistant Coaches, school insurance coordinator, the Principal, Primary Care Physician, Pediatrician and Referring Physicians.

It is not the practice of Southern Bone & Joint Specialists, to release individual health information to the media on any sports injury or health status. All such inquiries will be referred to the school or Head Sports Coach.

I acknowledge and agree with the above stated paragraphs and the **Notice of Privacy Practices** included in this packet.

Print Name of Student

Parent Signature

Student Signature

Date

Please list below the names of any individuals who we may disclose any medical and/or account billing information on your behalf. These people will be allowed to act as your personal representative.

NAME

RELATIONSHIP

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

History _____ Date _____

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Sport _____

Explain "Yes" answers below:		Yes	No
1.	Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been hospitalized or spent a night in a hospital? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you presently taking any medications or pills (prescription or over-the-counter)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain or discomfort in your chest during or after exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur, high cholesterol, or heart infection? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50? Does anyone in your family have a heart condition? Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had a head injury or concussion? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have trouble breathing or do you cough during or after activity? Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever been told you have sickle cell trait? Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
17.	When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____		
Explain "Yes" answers: _____ _____ _____			

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Students will not be permitted to participate in Interscholastic athletics unless there is on file in the Superintendent's or Principal's office a physician's statement for the current year certifying that the student has passed an adequate physical examination and that in the opinion of the examining physician he/she is fully able to participate in high school athletics.

Physical Examination

		Height _____	Weight _____	BP _____ / _____	Pulse _____
		Vision R 20/ _____	L 20/ _____	Corrected: Y N	
LIMITED		Normal	Abnormal Findings		
	Cardiovascular				
	Pulses				
	Heart				
	Lungs				
	Skin				
COMPLETE	E.N.T.				
	Abdominal				
	Genitalia (males)				
	Musculoskeletal				
	Neck	Flex	EXT	ROT	
	Shoulder	Delt	Sup	IR	ER
	Elbow	Flex	EXT		
	Wrist	Flex	EXT	PRO	SUP
	Hand	Grip			
	Back	Sco	Flex	EXT	
	Knee	Hams	Hiplflex	QUAD	Exam
	Ankle	HC			
	Foot				
	Other				

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for:

C. Not cleared for: Collision

Contact

Noncontact: _____ Strenuous _____ Moderately Strenuous _____ Nonstrenuous

Due to: _____

Recommendation: _____

Name of Physician: _____ Date _____

Address _____ Phone _____

Signature of Physician _____, M.D. or D.O.