Macon County Schools

MACON COMMUNITY HOSPITAL

2019-2020 STUDENT-ATHLETE SPORTS PHYSICAL PACKET

Please return to the school office no later than July 15, 2019

Macon County Schools

MACON COMMUNITY HOSPITAL

Athlete Information Form

Please complete entire form

Athlete Name: _____ Athlete Cell: _____ Birthdate: _____

Sex: M F Age: ___ Graduation Year: _____ Sport(s): _____ Athlete Email: _____

Allergies: _____ **Medications:** _____

Emergency Medical Conditions:_____

Primary Insurance Company: _____ Customer Service Phone #:_____

Subscriber ID: _____ Group #: _____

Primary Insurance Policy Holder (circle one): Athlete Mother Father OTHER: _____

Secondary Insurance Policy: _____ Customer Service Phone #: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance Policy Holder (circle one): Athlete Mother Father OTHER: _____

Primary Care Physician: _____ Office#: _____

Student Athlete
Home Address: _____ City _____ Zip _____

Mother (Guardian)'s Name: _____ Father's Name: _____

Mother's Cell #: _____ Father's Cell #: _____

Mother's Work #: _____ Father's Work #:_____

Employer: _____ Employer: _____

Email: _____ Email: _____

Emergency Contact (other than parents): _____

Emergency Contact Phone #:_____ Relationship: _____

CONSENT TO REPRESENT SCHOOL

I hereby give my consent for (student- athlete's name) _____ to represent **Macon County Schools** in the sport(s) of _____.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____Date:_____

PREPARTICIPATION PHYSICAL EVALUATION
THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS
UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL
SPORTS PHYSICAL RELEASE FORM

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"),as described below, to "Macon Community Hospital", its physicians, athletic trainers, and staff.

The information described below may be released to as necessary to evaluate the Student's eligibility to participate in, or continue to participate in, school sponsored interscholastic sports programs.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Preparticipation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in School sponsored interscholastic sports activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed by the School or by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations.

I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.
I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of School: _____School Address: _____

This authorization will expire when the student is no longer enrolled as a student at a school within Macon County.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature_____ Student Birth Date MM/ DD/ YYYY_____

Parent/Legal Guardian Signature_____Date_____

I am the Student's (check one): ___ Parent ___ Legal Guardian (documentation must be provided)

Macon County Schools

MACON COMMUNITY HOSPITAL

MEDICAL / HEALTH INFORMATION CONSENT FORM

STUDENT NAME: _____ SPORT(S): _____

PROTECTED HEALTH INFORMATION AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

I/We hereby authorize any medical provider associated with **Macon County Schools**, specifically Macon Community Hospital to use and/or disclose my child's clearance and health recommendations to the athletic director, coaches and medical personnel at **Macon County Schools** to inform them of their health status for the participation in athletic or activities. I/We understand 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 state or federal law.

_____
Parent/Guardian Initials

LEGAL MEDICAL CONSENT

I/We hereby give consent for (student-athlete's name) _____ to represent **Macon County Schools** in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still possible. On rare occasions these injuries are severe and result in total disability, paralysis, or even death. I/We further grant permission to **Macon County Schools** and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well-being of the student-athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student-athlete.

_____
Parent/Guardian Initials

ACKNOWLEDGMENT OF PERSONAL RESPONSIBILITY

I/We understand that it is my responsibility to notify **Macon County Schools** and its physicians and athletic trainers in writing of any and all injuries/illnesses, athletic or otherwise, suspected injury/illnesses, and any and all pre-existing conditions that may result in further injury/illness to me, teammates, opponents, and/or athletic staff.

_____
Parent/Guardian Initials

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____

Macon County Schools

MACON COMMUNITY HOSPITAL

Student-Athlete & Parent/Legal Guardian Concussion Education Sign-Off

Form must be completed for each student-athlete.

Student- Athlete Name (Print): _____

Parent/Legal Guardian Name (Print): _____

☐ *We have read the Student-Athlete & Parent/Legal Guardian Concussion Information Sheet (please check the box). After reading the information sheet, I am aware of the following information:*

Student Athlete Initials		*Parent/Legal Guardian Initials*
	A concussion is a brain injury, which should be reported to my parents, my coach(es), and/or my athletic trainer.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen". Some symptoms might be present right away, while other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or my athletic trainer about my injuries and illnesses.	*N/A*
	If I think that a teammate has a concussion, I will tell my coach(es), parents, and/or athletic trainer about the concussion.	*N/A*
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	*N/A*
	*I/my child will provide written permission from a *medical professional as defined by Tennessee law to return to play or practice after a concussion.*	
	I realize that the Emergency Room/Urgent Care physicians will not provide clearance if seen immediately after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Based on the latest data, concussions can take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

***Medical professional* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.**

_____ _____

Signature of Student-Athlete **Signature of Parent/Legal Guardian**

Date: _____ **Date:** _____

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 _____

©2010 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 acknowledgment.

HE0503 9-2681/0410

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		

[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

©2010 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 acknowledgment.

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs.SCA doesn't just happen to adults; it takes the lives of student s, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult' s SCA may be caused by either inherited or lifestyle issues.

SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to sudden ly stop beating.

How common is sudden cardiac arrest in the United States?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 - the Sudden Cardiac Arrest Prevention Act

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic act ivity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptom s:
  (i) Unexplained shortness of breath;
  (ii) Chest pains;
  (iii) Dizziness
  (iv) Racing heart rate; or
  (v) Extreme fatigue; and

- Establish as policy that a youth athlet e who has been removed from play shall not rreturn to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete Print Student-Athlete's Name Date

Signature of Parent/ Guardian Print Parent/Guardian's Name Date

Macon County Schools

MACON COMMUNITY HOSPITAL

Concussion Information for Students-Athletes and Parents/Legal Guardians ***(to be kept at home)***

What is a concussion? A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a fall or a blow to the body that causes the head and brain to move quickly back and forth. Even a "ding", "getting your bell rung", or what seems to be a mild bump or blow to the head can be serious.

Why is it important to recognize a concussion? Timely recognition and appropriate response is important in the treatment of a mild traumatic brain injury (MTBI) or concussion. A patient's health outcomes improve through early diagnosis, management, and appropriate referral following a concussion. Symptoms of a concussion may appear mild, but can lead to significant, life-long impairment affecting an individual's ability to function physically, cognitively, or psychologically.

How do I know if I have a concussion? There are many signs and symptoms that a patient may have following a concussion. A concussion can affect thinking, the way the body feels, mood, or sleep patterns. Look for the following:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
• Difficulty thinking clearly • Taking longer to figure things out • Difficulty concentrating • Difficulty remembering new information	• Headache • Blurry vision • Feeling sick to stomach • Vomiting • Dizziness • Balance problems • Sensitivity to noise and/or light	• Irritability-things bother you more easily • Sadness • Increased moodiness • Feeling nervous or worried • Crying more	• Sleeping more than usual • Sleeping less than usual • Trouble falling asleep • Feeling tired

What should I do if I think that I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the medical assistance that you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, your words are coming out funny/slurred, you should inform an adult, such as your parent or coach or teacher immediately. This will make sure that you get the medical help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school, or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have had a concussion, you are more likely to have another concussion.

How do I know when it is okay for me to return to physical activity and my sport after a concussion? After telling an adult that you think you have a concussion, you will be seen by a medical professional (Tennessee licensed medical doctor, osteopathic physician or clinical neuropsychologist) trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign that your brain has not recovered from the injury. For more information on concussions, visit www.cdc.gov/concussion.