



# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION

STUDENT'S NAME: \_\_\_\_\_

SPORT(S): \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ % OF BODY FAT: \_\_\_\_\_

PULSE: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_ / \_\_\_\_ ( \_\_\_\_ / \_\_\_\_ , \_\_\_\_ / \_\_\_\_ )

VISION: R 20/\_\_\_\_ L 20/\_\_\_\_ CORRECTED: Y N PUPILS: EQUAL \_\_\_\_ UNEQUAL \_\_\_\_

As a minimum requirement, this PHYSICAL EXAMINATION FORM must be completed prior to athletic participation *each* year.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in supine position			
Heart-Auscultation of the heart in the standing position			
Heart- Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*Station-based examination only

<p><b>CLEARANCE</b></p> <p><input type="checkbox"/> Cleared</p> <p><input type="checkbox"/> Cleared after completing evaluation/rehabilitation for: _____</p> <p><input type="checkbox"/> Not cleared for: _____ Reason: _____</p> <p>Recommendations: _____</p> <p>_____</p>
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Provider Name: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Provider Phone #: \_\_\_\_\_

Provider Address: \_\_\_\_\_



## PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY

This MEDICAL HISTORY FORM must be completed annually by parent/guardian and student in order for the student to participate in school sponsored athletic activities. These questions are designed to determine if the student has developed or experienced any condition which would make it hazardous to participate in an athletic event.

STUDENT'S NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PARENT CELL: \_\_\_\_\_ STUDENT CELL: \_\_\_\_\_

SCHOOL: **PARKVIEW CHRISTIAN ACADEMY** GRADE: \_\_\_\_\_ PERSONAL PHYSICIAN NAME: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

Explain any "Yes" answers on a separate piece of paper. Please circle questions for which you have no answer. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in practices, games or matches.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had chest pain during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you get tired more quickly than your friends do during exercise?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you experienced racing of your heart or skipped heartbeats?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had high blood pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high cholesterol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has any family member or relative died of heart problems before age 50?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has any family member or relative died of sudden unexpected death before age 50?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any family member been diagnosed with hypertrophic Cardiomyopathy?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has any family member been diagnosed with Long QT Syndrome?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has any family member been diagnosed with ion channelopathy (Brugada Syndrome, etc.)           | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has any family member been diagnosed with Marfan's Syndrome?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious, or lost your memory?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had numbness or tingling in your arms, hands, legs, or feet?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had a stinger, burner or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you missing any paired organs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are you presently under a doctor's care?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you currently taking any prescription or non-prescription medication or inhalers?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have any allergies?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been dizzy before or during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever become ill from exercising or working in the heat?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever gotten unexpectedly short of breath with exercise?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have seasonal allergies that require medical treatment?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you use any special protective or corrective equipment?                                     | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 37. Have you ever had a sprain, strain, or swelling after injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you broken or fractured any bones?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever dislocated any joints?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?<br>If yes, circle which one(s) and explain on a separate piece of paper. | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Neck Back Chest Shoulder Upper Arm Elbow Forearm<br>Wrist Hand Finger Hip Thigh Knee Shin/Calf Ankle Foot  |                          |                          |
| 41. Do you want to weigh more or less than you do now?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you lose weight regularly to meet weight requirements for your extra-curricular activities?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Do you feel stressed out?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |

**Females Only**

45. When was your first menstrual period? \_\_\_\_\_
46. When was your most recent menstrual period? \_\_\_\_\_
47. How many days elapse from the start of one period to the start of another? \_\_\_\_\_
48. How many periods have you had in the last year? \_\_\_\_\_
49. What was the longest number of days between periods in the last year? \_\_\_\_\_

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the athletic organization nor Parkview Christian Academy assumes any responsibility in case an accident occurs. The possibility of transfer of disease exists whenever blood transfer occurs. While the risk is minimal with high school activities, by signature below we recognize the possibility exists relating to blood borne pathogens and the transfer of disease such as Hepatitis or HIV.

If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

***I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful and complete responses could subject the student in question to penalties determined by the school or its athletic affiliates and authorities.***

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN NAME (PRINT): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*For School Use Only:*

**This Medical History Form reviewed by:**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## SUDDEN CARDIAC ARREST

### What is Sudden Cardiac Arrest (SCA)?

Sudden Cardiac Arrest is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. 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 of the heart's electrical system, causing the heart to stop beating.

### How common is Sudden Cardiac Arrest?

While studies differ in the actual rate of occurrence, the American Heart Association information indicates that there are approximately 300,000 SCA events outside hospitals each year in the United States. About 2000 patients under the age of 25 die of SCA each year. Studies now being performed in Texas and other states indicate the occurrence rate for high school age athletes may be great than this figure.

### Are there warning signs?

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

Dizziness	Fatigue	Lightheadedness	Extreme Tiredness
Shortness of Breath	Nausea	Difficulty breathing	Vomiting
Racing or fluttering heartbeat	Chest Pains	Syncope (fainting)	

These symptoms can be confusing and unclear in athletes. Often people confuse these warning signs as physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

For this reason, these symptoms are included on the Medical History form provided by Parkview Christian Academy and required for each student prior to participation in athletic events each year. As parents and student athletes, your truthful answers to these simple questions will assist your medical practitioner when performing the annual physical examination.

### What are the risks of participation and playing with these symptoms?

Continued participation bring with it increased risk. This includes playing in practices and games. 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 minutes. Most people who experience a SCA die from the event.

While Parkview Christian Academy doesn't mandate Cardiac Screening prior to participation, we recognize the importance of our students' health and highly recommend discussing screening options with your health care provider. Any student who shows signs of SCA should be removed by the parents from play. This includes all athletic activity, practices or contests. Before returning to play, the student should be examined and receive clearance by a licensed health care professional of the parents' choosing.

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

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## CONCUSSION AND TRAUMATIC BRAIN INJURY

### What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way a student's brain normally functions
- Can occur during practice or contests in any sport
- Can occur in activities both associated and not associated with the school
- Can occur even if the student has not lost consciousness
- Can be serious even if a student has just been "dinged" or had their "bell rung"

### What are the symptoms of a concussion?

Concussions cannot be seen: however, in a potentially concussed student, on or more of the following symptoms may become apparent. The student may not "feel right" soon after, a few days or even weeks after the injury event. Some people may have signs or symptoms, such as:

Headache	"Pressure" in the head	Nausea	Vomiting
Balance Problems	Dizziness	Blurry Vision	Double Vision
Sensitivity to Light	Sensitivity to Noise	Confusion	Memory Problems
Difficulty paying attention	Feeling sluggish, hazy, foggy or groggy		

If you have concerns regarding any of the above symptoms, your doctor should be consulted for further information and/or examination. Your physician or medical professional can best determine your student's physical condition and ability to participate in athletics.

### What should students do if they believe that they or someone else may have a concussion?

- Students should immediately notify their coach or school personnel.
- Student should be examined by appropriate medical personnel of the parent's choosing. The medical provider should be trained in the diagnosis and treatment of concussions.
- If no concussion is diagnosed, the students shall be cleared to returned to athletic participation.
- If a concussion is diagnosed, the school protocol for return to play from a concussion shall be enacted. Under no circumstances shall the student be allowed to return to practice or play without the approval of a licensed medical provider trained in the treatment of concussions.

**I have reviewed the above material. I understand the symptoms and warning signs of CONCUSSIONS. All concussions should be reported to the school as soon as possible. Previous concussions should be reported on the Medical History form to allow the medical practitioner the best information possible when conducting the annual physical examination.**

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONCUSSIONS—Don't hide it. Report it. Take time to recover.**