PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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?
   - 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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SIH

Concussion Management Policy

The following policy is for all athletes and athletic teams at Anna-Jonesboro Community Unit School District No. 81. AJHS contracts Certified Athletic Trainers for Sports Medicine, this policy was formed and based on the Consensus Statement on Concussions in Sport: The 3rd International Conference on Concussion in Sports held in Zurich, 2008. The policy is in ordinance with IHSA guidelines and The National Athletic Trainers Association policy and procedures for concussions.

Definition of Concussion:

Sports concussion is defined as a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces (with or without the loss of consciousness).

Defining The Nature of a Concussive Head Injury:

1. Concussion may be caused either by a direct blow to the head, face or neck or a blow elsewhere on the body with an "impulsive" force transmitted to the head.
2. Concussion typically results in the rapid onset of short-lived impairments of neurologic function that resolves spontaneously.
3. Concussion may result in neuropathological changes, but the symptoms largely reflect functional disturbances rather than a structural injury.
4. Concussion may or may not involve loss of consciousness,
5. No abnormality on standard neuroimaging tests. (Neuro test can not detect concussions)

Pediatric Concussive Injury:

Children, ages (5-18) years old should not return to playing or training until clinically completely symptom free. Due to the physiological response during childhood head trauma, a conservative return to play approach is recommended. ***It may be appropriate to extend the amount of time of asymptomatic rest and/or length of the graded exertion in children and adolescents due to type of injury or history of previous concussions.***

Concussion Management:

To ensure appropriate management of concussions, baseline cognitive testing will be administered to all AJHS athletes prior to participation in sport. Concussion injuries will be appropriately managed by SIH Sports Rehabilitation Physicians, Primary Care Physicians or by Certified Athletic Trainers working under medical supervision. Concussion management ideally includes rest until all symptoms resolve and then implementing a graded program of exertion before return to sport.

When a player shows <u>ANY</u> symptoms or signs of a concussion:

1. The player will not be allowed to return to play the same day.
2. The player will not be left alone; and serial monitoring for deterioration will be essential over initial few hours following injury.
3. The player will be medically evaluated following injury with the use of the SCAT (Standardized Concussion Assessment Tool), or similar exam on the sideline, MD office or Athletic Training Room.
4. Return to participation must follow a medically supervised stepwise process. (See RTP protocol)
5. A Concussion information handout will be given to athlete, parent/guardian or friend of the athlete who is taking care of them.

A PLAYER WILL NOT BE RETURNED TO PLAY WHILE SYMPTOMATIC.

<u>Return to Participation (RTP) Protocol</u>

. Activities that require concentration and attention may exacerbate the symptoms and as a result delay recovery. Therefore, during the period of recovery, following injury, it is important to emphasize to the athlete that physical AND cognitive rest is required

The return to participation following a concussion follows a stepwise process:

I No activity, complete rest. Once asymptomatic, proceed to levels using the **Following:**

A. Light aerobic exercise such as walking, or stationary cycling, no resistance training.
B. Sport specific exercise (skating in hockey, running in soccer, etc) progressive addition of resistance training at steps b or c.
C. Non-contact training drills.
D. Full contact training and or exertional testing after medical clearance.
E. Game play.

This progression will proceed over several days, but will be dependent on the athlete's progress with the resolve of symptoms.

With this stepwise progression, the athlete will continue to proceed to the next level if asymptomatic at the current level. If any post concussion symptoms occur, the patient will drop back to the previous asymptomatic level and try to progress again after 24 hours. Return to play process will be monitored by SIH Sports Rehabilitation staff.

SIH

The above policy will be followed by the healthcare professionals (Team Physician, Athletic Trainers along with the Athletic Department) that deal with the return to play of the student athletes. **This concussion management, return to play protocol will be followed despite the athlete presenting a prescription note to return to play sooner from their primary care physician or Emergency room.** If the athlete presents a prescription from their primary care physician for the appropriate time frame in regard to return to participation, then the exertional progressive steps will be followed by the Athletic Trainer using the RTP protocol.

I _____, the parent/guardian of _____ has read and fully understand the concussion policy. I am fully aware of the risk associated with playing sports and will adhere to the policy to help minimize serious injury related to sports related concussions.

_____ _____

parent/guardian signature Date

Policy written by SIH Sports Rehabilitation Team,
Certified Athletic Trainers 2011