ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 copy of this form in the chart.) Date of Exam Date of birth Name 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 ☐ Yes ☐ No If yes, please identify specific allergy below. Do you have any allergies? ☐ Medicines □ Food ☐ Stinging Insects ☐ Pollens Explain "Yes" answers below. Circle questions you don't know the answers to. **MEDICAL QUESTIONS** No Yes **GENERAL QUESTIONS** No 26. Do you cough, wheeze, or have difficulty breathing during or 1. Has a doctor ever denied or restricted your participation in sports for after exercise? any reason? 27. Have you ever used an inhaler or taken asthma medicine? 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections 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 3. Have you ever spent the night in the hospital? (males), your spleen, or any other organ? 30. Do you have groin pain or a painful bulge or hernia in the groin area? 4. Have you ever had surgery? **HEART HEALTH QUESTIONS ABOUT YOU** 31. Have you had infectious mononucleosis (mono) within the last month? Yes No 32. Do you have any rashes, pressure sores, or other skin problems? 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? 33. Have you had a herpes or MRSA skin infection? 6. Have you ever had discomfort, pain, tightness, or pressure in your 34. Have you ever had a head injury or concussion? chest during exercise? 35. Have you ever had a hit or blow to the head that caused confusion. 7. Does your heart ever race or skip beats (irregular beats) during exercise? prolonged headache, or memory problems? 8. Has a doctor ever told you that you have any heart problems? If so, 36. Do you have a history of seizure disorder? check all that apply: 37. Do you have headaches with exercise? ☐ High blood pressure A heart murmur 38. Have you ever had numbness, tingling, or weakness in your arms or ☐ High cholesterol ☐ A heart infection legs after being hit or falling? ☐ Kawasaki disease Other: 39. Have you ever been unable to move your arms or legs after being hit 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, or falling? echocardiogram) 40. Have you ever become ill while exercising in the heat? 10. Do you get lightheaded or feel more short of breath than expected during exercise? 41. Do you get frequent muscle cramps when exercising? 11. Have you ever had an unexplained seizure? 42. Do you or someone in your family have sickle cell trait or disease? 12. Do you get more tired or short of breath more quickly than your friends 43. Have you had any problems with your eyes or vision? during exercise? 44. Have you had any eye injuries? **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** Yes No 45. Do you wear glasses or contact lenses? 13. Has any family member or relative died of heart problems or had an 46. Do you wear protective eyewear, such as goggles or a face shield? unexpected or unexplained sudden death before age 50 (including 47. Do you worry about your weight? drowning, unexplained car accident, or sudden infant death syndrome)? 48. Are you trying to or has anyone recommended that you gain or 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT lose weight? syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic 49. Are you on a special diet or do you avoid certain types of foods? polymorphic ventricular tachycardia? 50. Have you ever had an eating disorder? 15. Does anyone in your family have a heart problem, pacemaker, or 51. Do you have any concerns that you would like to discuss with a doctor? implanted defibrillator? **FEMALES ONLY** 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? 52. Have you ever had a menstrual period? **BONE AND JOINT QUESTIONS** 53. How old were you when you had your first menstrual period? Yes No 17. Have you ever had an injury to a bone, muscle, ligament, or tendon 54. How many periods have you had in the last 12 months? that caused you to miss a practice or a game? Explain "yes" answers here 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? 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

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

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NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ 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?
 Consider reviewing questions on cardiovascular symptoms (questions 5–14). **EXAMINATION** Height ☐ Male Weight ☐ Female Vision R 20/ L 20/ Pulse Corrected DY DN MEDICAL ABNORMAL FINDINGS 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) · Simultaneous femoral and radial pulses Lungs Abdomen Genitourinary (males only)^b · HSV, lesions suggestive of MRSA, tinea corporis Neurologic o MUSCULOSKELETAL Neck Back Shoulder/arm Elbow/forearm Wrist/hand/fingers Hip/thigh Knee Leg/ankle Foot/toes **Functional** · Duck-walk, single leg hop ^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. ^aConsider GU exam if in private setting. Having third party present is recommended. *Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. ☐ Cleared for all sports without restriction $\hfill \Box$ 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 _ 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, a 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, advanced practice nurse (APN), physician assistant (PA) (print/type)_ Phone_

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Signature of physician, APN, PA

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM Cov. CL. M. Cl. E. Ann. Date of birth

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