GEORGIA

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HIGH SCHOOL ASSOCIATION

TO: Whom It May Concern

FROM: Georgia High School Association

DATE: August, 2011

RE: Pre-Participation Physical Evaluation; pages 3-4

As per Georgia High School Association By-Law 1.41(c) and the new State of Georgia law, the "Pre-Participation Physical Evaluation" form may be signed by a licensed Nurse Practitioner or a Physician's Assistant provided this person has been delegated that task by an M.D. or D.O. Alterations (edits) to this copyrighted document are not permitted. Therefore, the doctor or his/her designee may print and then sign his/her (their) name on the appropriate line(s) found on page 3 and page 4 of the physical form.

■ 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 Sch	x Age Grade School Sport(s)					
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking		
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	ecific al	lergy below. □ Food □ Stinging Insects			
Explain "Yes" answers below. Circle questions you don't know the an	swers t	о.				
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No	
 Has a doctor ever denied or restricted your participation in sports for any reason? 			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?			
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			28. Is there anyone in your family who has asthma?	\vdash		
3. Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?			
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?			
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?			
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?	<u> </u>		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?	—		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, 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?	\vdash		
check all that apply: ☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?			
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?			
10. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?	ــــــ		
during exercise?			41. Do you get frequent muscle cramps when exercising?	—		
11. Have you ever had an unexplained seizure?12. Do you get more tired or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease?	\vdash		
during exercise?			43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries?	\vdash		
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?	\vdash		
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?			
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or 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? 15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?	<u> </u>		
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?			
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY			
seizures, or near drowning? BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period? 53. How old were you when you had your first menstrual period?	+		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon	162	NO	54. How many periods have you had in the last 12 months?	\vdash		
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?						
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?			İ			
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		•	·			
Signature of athlete Signature of	of parent/g	juardian _	Date			

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Ex	am					
Name				Date of birth		
Cov	Ago	Crado	School			
26x	Age	Grade	501001	Sport(s)		
1. Type o	of disability					
	of disability					
3. Classit	fication (if available)					
4. Cause	of disability (birth, d	isease, accident/trauma, other)				
	e sports you are inte	<u></u>				
					Yes	No
6. Do you	u regularly use a bra	ce, assistive device, or prostheti	c?			
7. Do you	u use any special bra	ace or assistive device for sports	9?			
8. Do you	u have any rashes, p	ressure sores, or any other skin	problems?			
9. Do you	u have a hearing loss	s? Do you use a hearing aid?				
10. Do you	u have a visual impa	irment?				
11. Do you	u use any special de	vices for bowel or bladder functi	ion?			
12. Do you	u have burning or dis	comfort when urinating?				
13. Have y	you had autonomic d	ysreflexia?				
			hermia) or cold-related (hypothermia) illnes	ss?		
15. Do you	u have muscle spasti	city?				
16. Do you	u have frequent seizı	ures that cannot be controlled by	y medication?			
Explain "ye	es" answers here					
Dloogo indi	ionto if you have ov	er had any of the following.				
i icase iliui	cate ii you nave ev	er flad any of the following.			Yes	No
Atlantoaxia	al instability				163	140
	uation for atlantoaxia	al instahility				
	l joints (more than or					
Easy bleed	-					
Enlarged s						
Hepatitis						
_	a or osteoporosis					
	controlling bowel					
	controlling bladder					
Numbness	or tingling in arms of	or hands				
	or tingling in legs o					
Weakness	in arms or hands					
Weakness	in legs or feet					
Recent cha	ange in coordination					
Recent cha	ange in ability to wal	k				
Spina bifid	la					
Latex aller	gy					
Evnlain "vo	es" answers here					
Explain yo	33 dilawera nere					
I hereby sta	ate that, to the best	of my knowledge, my answe	rs to the above questions are complete	and correct.		
I hereby sta		of my knowledge, my answe	rs to the above questions are complete a	and correct.	Date	

PHY	SICA				YSICAL	. — -			Dat	te of birth			
Have you ever Do you wear a Consider reviewing	al questions on messed out or under stad, hopeless, or at your home or ried cigarettes, consolor or use any aken anabolic staken any supple seat belt, use a h	er a lot of pr depressed, r residence' chewing tob u use chewi other drugs eroids or us ments to he pelmet, and	ressure or anx ? acco, ng tob 6? sed an elp you use co	e? cious? snuff, or dip? vacco, snuff, or d y other performa u gain or lose we ondoms?	ance supplement? eight or improve you	ır perforn	nance?						
EXAMINATION		144-1	. 1. 1			7. 84-1-							
Height		Wei			L	□ Male							
BP /	(/)	Pulse		Vision F		L 2	20/		Corrected		N
MEDICAL							NORMAL			ABNO	ORMAL FINE	JINGS	
Appearance • Marfan stigmata arm span > heig					atum, arachnodacty	yly,							
Eyes/ears/nose/throPupils equalHearing	at												
Lymph nodes													
Heart ^a • Murmurs (auscu • Location of point			Valsal	va)									
Pulses • Simultaneous fe	noral and radial _l	pulses											
Lungs													
Abdomen													
Genitourinary (male	s only) ^b												
Skin • HSV, lesions sug	gestive of MRSA,	tinea corpo	ris										
Neurologic ^c													
MUSCULOSKELET	\L												
Neck													
Back													
Shoulder/arm													
Elbow/forearm													
Wrist/hand/fingers													
Hip/thigh													
Knee													
Leg/ankle													

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider 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.

ш	Cleared for	all sports	without	restriction

Duck-walk, single leg hop

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _

□ Not cleared

Functional

□ 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, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

,	
lame of physician (print/type)	Date
Address	Phone
Smoothers of physician	MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

Name		Sex 🗆 M 🗆 F Age	Date of birth
☐ Cleared for	r all sports without restriction		
☐ Cleared for	r all sports without restriction with recomme	ndations for further evaluation or treatment for	
□ Not cleared	d		
	Pending further evaluation		
	1 For any sports		
	1 For certain sports		
	Reason		
Recommendat	tions		
I have exam	nined the above-named student and o	completed the preparticipation physical evaluation. 1	The athlete does not present apparent
		pate in the sport(s) as outlined above. A copy of the	
		equest of the parents. If conditions arise after the at	
		e problem is resolved and the potential consequence	es are completely explained to the athlete
(and parent	s/guardians).		
Name of physi	ician (print/type)		Date
EMERGEN	CY INFORMATION		
Allergies			
Other informat	tion		
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