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 _____

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. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve 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

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete _____ _____
Date

Signature of Parent/Guardian _____ _____
Date

Bishop England Sports Medicine

Rehabilitation Centers RCC of Charleston

EMERGENY REPSONSE FORM

LAST NAME: _____**SPORT**: _____

FIRST NAME: _____**SPORTS 2 & 3**: _____

GRADE: 7TH 8TH 9TH 10TH 11TH 12TH **SCHOOL**: _____

BIRTH DATE: _____/_____/_____ ____ M ____ F

ADDRESS: _____**CITY**: _____**ZIP**: _____

HOME PHONE NUMBER(s): _____ / _____

PARENTS/LEGAL GUARDIAN

MOTHER'S NAME: _____ **WORK NUMBER**: _____

FATHER'S NAME: _____ **WORK NUMBER**: _____

Email Address: _____

SECONDARY EMERGENCY CONTACT **NAME**: _____

RELATIONSHIP: _____ **PHONE NUMBER**: _____

ALLERGIES: _____

SPECIAL MEDICAL CONCERNS: _____

NAME OF INSURANCE CO.: _____

POLICY #: _____ **DATE OF POLICY:** _____/_____/_____

FAMILY PHYSICIAN: _____ **PHONE NUMBER**: _____

As the parent(s) or legal guardian(s) of (Name of athlete) _____, I give my consent for his/her practice and play in athletic events. I verify that my child has adequate health insurance through the above-mentioned insurance company. I do not hold the school responsible in any way whatsoever. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history filled out on the physical form is accurate to the best of my knowledge.

My signature also verifies that my child and I have completely read and understand this handbook.

I completely understand the above and authorize my consent:

Signed _____ Date: _____

(Father, Mother, or legal guardian)

Rehabilitation Centers RCC of Charleston

Risk Acknowledgement

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous things in which any student will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMENENT PARALYSIS FROM THE NECK DOWN OR DEATH. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate risk.

Participants can, and have the responsibility to, help reduce the chance of injury. PARTICIPANTS MUST OBEY ALL RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACH AND ATHLETIC TRAINER, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.

By signing this statement, we acknowledge that we have read and understand this warning.

_____ _____/_____/_____ _____

STUDENT-ATHLETE'S SIGNATURE DATE PARENT/GUARDIAN SIGNATURE

****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, nurse, physical therapist, or athletic trainer who has attended me/my child, or any hospital or infirmary at which I have been treated or admitted, to furnish RCC, through our referral physician network, Bishop England's ATC copies of any information, notes, or hospital records concerning attendance upon, treatment, care, or confinement of the student-athlete undersigned. This authority extends to all records, including history, diagnostic tests, copies of findings, x-rays, examinations, consultation, opinions of physicians and surgeons or other medical personnel who may have any knowledge of any condition, examination or treatment of the student-athlete undersigned.

Athlete's Name: _____ Date of Birth: _____/_____/_____

(PLEASE PRINT)

Social Security Number: _____-_____-_____ Sport: _____

_____ _____/_____/_____ _____

STUDENT-ATHLETE'S SIGNATURE DATE PARENT/GUARDIAN SIGNATURE

Bishop England Sports Medicine

Greg Banks, ATC, CSCS – (843) 364-7214
Heather Bellin ATC - (843) 270-2386

Rehabilitation Centers RCC of Charleston

BISHOP ENGLAND CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of Bishop England High School, the State of South Carolina has mandated that all athletes, parents/guardians and coaches follow the SC Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

Athletes with the signs and symptoms of concussion will be removed from play immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider. You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out. For current and up-to-date information on concussions you can go to:

Bishop England Sports Medicine
Greg Banks, ATC, CSCS – (843) 364-7214
Heather Bellin ATC - (843) 270-2386

Rehabilitation Centers RCC of Charleston

What to Expect When You See a Health Care Professional

While most are seen in an emergency department or medical office and discharged home, some people are hospitalized overnight. Your health care professional may do a scan of your brain (such as a CT scan) or other tests. Other tests, known as "neuropsychological" or "neurocognitive" tests, assess your learning and memory skills, your ability to pay attention or concentrate, and how quickly you can think and solve problems. These tests can help your health care professional identify the effects of a concussion. Even if the concussion doesn't show up on these tests, one may still be present.

The length to recover from a concussion depends upon several factors. No two concussions are alike and the recovery time is never predictable. Severity of the blow, age, health of the athlete, prior history of a head injury and how well the athletes takes care of themselves after the injury are major factors to consider in the recovery of this injury.

Getting Better:

- Get plenty of sleep at night, and rest during the day.
- Avoid activities that are **physically demanding** (e.g., heavy housecleaning, weightlifting/working-out) or require a **lot of concentration** (e.g., school work). They can make your symptoms worse and slow your recovery.
- Avoid activities, such as contact or recreational sports, that could lead to another concussion.
- Avoid sustained computer use, including computer/video games early in the recovery process.
- Also avoid texting on cell phones

For More information:

http://www.cdc.gov/ConcussionInYouthSports/

http://www.nata.org/sites/default/files/MgmtOfSportRelatedConcussion.pdf

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Rehabilitation Centers RCC of Charleston

Bishop England High School Concussion Policy (**Return this page signed**)

If a student athlete suspects that he or she has a concussion, it is the student- athlete's responsibility to report the incident and their symptoms to the athletic trainer, team physician, or healthcare professional immediately. The student- athlete should not continue practice or play if they are concerned that he/she might have been injured.

If a coach or athletic trainer suspects that a student athlete might have a concussion, the athlete must be removed from participation immediately and is not permitted to return that day. The Bishop England Athletic Trainer must see the injured athlete at the first available opportunity to evaluate the extent of the injury and will test the athlete according to the most appropriate testing criteria.

Medical clearance from a doctor is required to allow the athlete to proceed to the Graduated Return to Play Program. After receiving this clearance, the athlete may be eligible for full participation in no less than 4 days. The athlete must successfully complete the program before returning to play.

Graduated Return to Play Program & Criteria - Once an athlete no longer has signs, symptoms, or behaviors of a concussion **and is cleared to return to activity by an MD or DO**, he/she should proceed in a step-wise fashion to allow the brain to re-adjust to exercise. The athlete will progress **one step each day**. The return to activity program schedule **may** proceed as below **following medical clearance**:* **Medical clearance by a MD or DO is required by SC state law.***

***Step 1*:** Light aerobic exercise- 5 to 10 minutes on an exercise bike or light jog; no weight lifting, resistance training, or any other exercises.

***Step 2*:** Moderate aerobic exercise- 15 to 20 minutes of running at moderate intensity in the gym or on the field without a helmet or other equipment.

***Step 3*:** Non-contact training drills in full uniform- weight lifting, resistance training, and other exercises.

Step 4: Full contact practice or training.

Step 5: Full game play.

If symptoms of a concussion re-occur, or if concussion signs are observed at any time during the return to activity program, the athlete must discontinue all activity and be re-evaluated by their health care provider. When situation is resolved, the athlete returns to step 1. I understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have read and understand the Bishop England Concussion Policy and understand the importance of reporting symptoms of a head injury/concussion. I further understand that it is my responsibility to report to my coach or Athletic Trainer if I possibly have a concussion or any other injury.

_____ _____

Student Athlete Name (print) **Student Athlete Signature & Date**

_____ _____

Parent/Guardian Name (print) **Parent/Guardian Signature & Date**

Bishop England High School

Home of the Battling Bishops

Athletic Program Student Transportation Waiver

As the parent/guardian of _____, a _____ grade student
(Student's name) (Grade)
at Bishop England High School and participant in _____,
(Sport)
I give my permission for her/him to use transportation, other than school-provided transportation, to travel to and from practices and games/matches.
I understand that Bishop England High School cannot be responsible for assigning or monitoring with whom my child rides, and I hereby waive and fully and forever discharge the Diocese of Charleston, Bishop England High School, and all of its administrators, teachers and staff, supervisors, agents, and coaches, from liabilities, claims, demands, suites and causes of action of every kind in any way relating to or arising out of her/his participation in the above activity.

_____ _____

(Signature of Parent/Guardian) (Date)

Bishop England High School
363 Seven Farms Drive
Charleston, SC 29492-7534

ATHLETIC DEPARTMENT
PHONE (843) 849-9599
EXT. 153

ATHLETIC INSURANCE REPORT

My son/daughter _____ has adequate health coverage with:

Name of Insurance Co._____

Insurance Co. Policy Number_____

Date of Policy_____

INSURANCE: student accident insurance is provided to all students at no cost. This policy insures the student to and from school, during school, and while participating in school-sponsored programs. A separate brochure explaining this coverage can be obtained from the school. Students participating in competitive sports, including football, will be covered.

A twenty-four hour policy is available to students – information may be obtained through the school office.

ALL ATHLETES AND CHEERLEADERS MUST PAY A $5.00 FEE (per year) to cover their PARTICIPATION in CATASTROPHIC INSURANCE COVERAGE. This particular coverage has been mandated by The High School League, and DOES NOT SERVE IN PLACE OF MEDICAL COVERAGE. The catastrophic coverage begins at $25,000 and continues to $5,000,000.

I accept full responsibility for any emergency medical service, which may be deemed necessary by the coaching staff arising from his/her participation in athletics

_____ _____

(Date) (Signature of Parent/Guardian)

Please list any allergies to medicine that your son/daughter might have or any medication he/she might be taking:

_____ _____

Parent/Guardian Phone Numbers Emergency Contacts/Phone No.

_____ _____

_____ _____

_____ _____