Sports Preparticipation Health Evaluation

To be completed and signed by the athlete and parent/guardian if athlete is less than 18 years of age. A current sports physical is one performed on or after April 15 of the previous school year.

Student Name:	Last	Fin	st	Middle		M	Sex F	Date of Birth	Age	Today's /	Date:
	ber & Street Name		City	State	Zip		·	Student's Phone: Home:	Cell:	,	
Name of Father/Guardia	in: Phone	e#:			Name of Mother/Guar	rdian:		Phone#:			
School:	Grade):			Sports Activities:						
I hereby state that, to Student athlete signal	the best of my knowledge, to ture:	he follov	ving me		tion is correct. I autho Jardian signature:	rize Dr.	·	to	perform this e Today's dat		1. /
				MEDIC	AL HISTORY						
	L QUESTIONS d or restricted your participation	Y		YOUR FAMILY'S HEART Does anyone in your fan right ventricular cardiom syndrome?	nily have arrhythmogenic	Y	N	MEDICAL QUI 43. Do you cough, wheeze, o breathing during or after	or have difficulty		YN
 Do you have any ongoin Asthma, Anemia, Diabet 	g medical conditions? Such as es, Infections or Other		25.	Has any family member problems or had an une	xpected or unexplained			44. Were you born without or organ? Identify by circling	g: Kidney Eye	an	
3. Do you regularly take me the-counter?	edication (prescription or over				e 50 (including drowning, t or sudden infant death			Spleen Testicle (m Any other organ:	ales)		
4. Do you have any allergies other)?			26.	Does anyone in your far catecholaminergic polyn	norphic ventricular			45. Do you or someone in you trait or disease?		e cell	
Have you ever had surge hospital?	ery or spent the night in the			tachycardia, short QT sy	ndrome?			46. Have you ever had an ea	ting disorder?		
HEART HEALTH QUESTION	S ABOUT YOU	Y	N	BONE AND JOIN	T QUESTIONS	Y	N	47. Do you worry about your	weight?		
6. Have you ever passed o or AFTER exercise?	ut or nearly passed out DURING			Have you ever had an ir ligament or tendon that practice or a game?				48. Are you trying to or has a that you gain or lose weight	nyone recommend ht?		
in your chest during exe				or dislocated joints?	proken or fractured bones			49. Are you on a special diet types of foods?			
 Do you get lightheaded of expected during exercise 	or feel more short of breath than ?				njury that required xrays, , therapy, a brace or cast			50. Have you ever had a hea If yes, How many?		sion?	
Do you get more tired or your friends during exerce	short of breath more quickly than ise?			Have you ever been told instability or atlantoaxial syndrome or Dwarfism)?	instability (Down			51. Have you ever had a hit of caused confusion, prolony memory problems?		d that	
10. Has a doctor ever order For example: ECG / EK			31.		rav for neck instability or			52. Have you ever had numb weakness in your arms o falling?		nit or	
 Have you ever had an u have a history of seizure 	nexplained seizure or do you e disorder?		32.		prace, orthotics, or other			53. Have you ever been unables after being hit or falli		ns or	
during exercise?	ce or skip beats (irregular beat)			warm or look red?	ome painful, swollen, feel			54. Do you wear protective ey or a face shield?			
pressure?	rou that you have high blood			Do you have any history connective tissue diseas				 Have you had any proble vision or had any eye inju 		or	
14. Has a doctor ever told y cholesterol?	ou that you have high ou that you have Kawasaki			Have you ever had a str Do you have a bone, mu				56. Do you wear glasses or o 57. Have you ever had herpe			\perp
disease?	ou that you have Kawasaki			bothering you?	, , , ,			 57. Have you ever had herpe infection? 58. Have you had infectious in 		no)	
problems? 17. Has a doctor ever told y	-		27			Y	N	 S8. Have you had infectious i within the last month? 59. Do you have any rashes, provide the second se	*	,	
infection?	ou that you have a heart murmur?				PV, Chicken pox, MMR)?			skin problems? 60. Do you have any concerr			
				ate of your most r		I .	1	discuss with a doctor?			
YOUR FAMILY'S HEART HE		Y	N 20	MEDICAL QU		Y	N	FEMALES	ONLY		Y N
 Does anyone in your fai pacemaker, or implante Does anyone in your fai 	d defibrillator?			heat?	ill while exercising in the			61. Have you ever had a men		volvo	
	syndrome, Brugada syndrome?			Do you have headaches cramps when exercising				62. How many periods have ye (12) months?		veive	
 21. Anyone in your family h 22. Anyone in your family h 				groin?	amily who has asthma?			63. How old were you when y menstrual periods?	you had your first	Age:	
	ad unexplained seizures? ad unexplained near drowning?	\vdash			inhaler or taken asthma						
				medicine?				Date of most recent n	nenstrual peri	od: /	1

Use this space for details of any "Yes" answers above or any additional health history:

PARENT / ATHLETE SECTION (PLEASE COMPLETE)

PHYSICAL EXAMINATION													
BMI:	Height:	Weight:	Male / Female	BP: / Pulse: Vision: R20/		L20/			Corrected: Yes / No				
MEDICAL				Ν	Α	NE		DETAILS	MUSCULOSKELETAL	Ν	Α	NE	DETAILS
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus												Deformity, ROM, Strength, Instability	
excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP,							Neck						
aortic insuffiency)									Back				
HEENT: anisocoria, hearing deficits, deviated septum, dental, braces								Shoulder/Arm					
Heart: Murmurs (auscultation standing/supine/+/- Valsalva) PMI							Elbow/Forearm						
Pulses: ra	adial, femoral (coarcta	tion)							Wrist/Hand/Fingers				
Lungs: who	eezing, rhonchi, rubs								Hip/Thigh				
Abdomen:	tenderness, organome	galy, bruits							Knee				
Genitalia:	undescended / absent	testicle, hernia							Leg/Ankle				
Skin: acne	e, furuncles / carbuncle	s, impetigo, herpes							Feet/Toes				
Neuro/Psyc	ch: head/C-spine inju	y, sensory/motor de	ficits, depression signs						Functional: Duck Walk				
Ancillary Te	estina: BESS Sco	re (balance testing)	(2 diait)		В	aseli	ine Neuro/	Psvch Test: Y / N	RS: S:				SS: EKG: Y / N

N=Normal; A=Abnormal; NE=Not Examined

Sports Preparticipation Health Evaluation

Student Last Name:	First	Middle			Today's Date:							
	EMERGENCY INFO	RMATION / MEDICAL TREA	TMENT CONSENT									
Emergency Contact Name: Phone#: Relationship:												
Personal Physician Name:	F	Phone#:	1									
Current Medications: (None) (list prescribed and over the counter medications)			Alle	ergies: (🗖 None)								
MEDICAL TREATMENT CONSENT: I, result of athletic participation, medical treatment on emergency medical care. I do hereby consent in ad assume the expenses of such care.	an emergency basis may be		nize that school personr	el may be unable to contact me for								
Signature of PARENT OR GUARDIAN OR 18-YEA	R OLD	Date										
	SIGNATURES CON	SENTING TO CONDITIONS O	OF PARTICIPATION									
STUDENT PARTICIPATION & PARENT OR GUA The information submitted herein is truthful to the b information that meets Michigan Department of He athletics, I/we do hereby agree, understand, appre contact and that there is inherent risk of personal claims, suits, losses, actions, or causes of action a and affiliates based on any injury to me, my child, participation in an MHSAA-sponsored sport. I/we understand that I am/we are expected to adh	est of my knowledge. By my ealth and Human Services a eciate, and acknowledge: th injury associated with partii against the MHSAA, its mer or any person, whether bec	/my child's signature below, ind MHSAA requirements. Fu at participation in such athlet cipation in such activities, wh nbers, officers, representative cause of inherent risk, acciden	/we acknowledge that I rther, in consideration of ics is purely voluntary; i ich risk I/we assume; an es, committee-members nt, negligence, or othen	of my/my child's participation in M that such activities involve physica nd that I/we agree to, and hereby, s, employees, agents, attorneys, ir wise, during or arising in any way	HSAA-sponsered al exertion and waive any and all nsurers, volunteers,							
Our son/daughter agrees to comply with the specific insurance regulations of the school district.												
The student-athlete has health insurance: Yes No If yes, Family Insurance Co.: Contract #												
I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.												
				-								
Signature of PARENT OR GUARDIAN OR 18-YEA	ROLD	Date										
Signature of STUDENT		Date		•								
	EVALUATION RES	SULTS / RECOMMENDATIO	NS / CLEARANCE									
ASSESSMENT		DISPOSIT	ION									
1. D No significant health concerns affecting spo	rts participation	1. 🗖 Spo	1. Given Sports health issues discussed									
2		2										
3		3										
4												
5.												
Counseling: (circle all that apply): Diet, injury pre	evention, injury managemen	it, immunizations										
		CLEARANCE STATEMENT										
I certify that the above student has been medically e (1) Participate in all school interscholastic activi (2) Requires further evaluation before a final re-	evaluated and is deemed to l ties without restrictions.	pe physically fit to: (Check On	,	S:								
□ (3) Not cleared for: □ All Sports □ Specif	ic Sports: (Cross out specifie	c sports below not cleared for	participation)									
Collision Contact Sports		Limited Contact Sports		Non-Contact S								
Basketball Ice Hockey Boys Lacrosse Soccer Diving Wrestling Football	Baseball Competitive Cheer Girls Lacrosse Girls Gymnastics	Alpine Skiing Girls Softball	Girls Volleyball Track Field Events High Jump Pole Vault	Cross Country Trac Golf D Swimming S	k Running k Field Events liscus hot Put							
Tennis I have reviewed and detailed the history and have performed a physical examination on the above named athlete 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 provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).												
Examiner Signature:	Print Examiners	Name:	Office P	hone: Date	:: <u>///</u>							
COPY BOTH SIDES OF THIS FORM FOR THE S THE ENTIRE FORM IN THE STUDENTS MEDICA		HE SCHOOL AND KEEP										

PHYSICIAN SECTION