■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

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* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), methicillin-resistant *Staphylococcus aureus* (MRSA), ortinea 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		

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings

☐ **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 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).

Name of provider: _____ Date of exam: _____

Address: _____ Phone: _____

Signature of physician, APN, PA: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM- Page 1

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 _____

Have you had COVID-19?: ☐ Yes ☐ No

Have you been immunized for COVID-19?: ☐ Yes ☐ No

If yes, you have had: ☐ One shot ☐ Two shots

List past and current medical conditions:

_____

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

_____

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

_____

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

_____

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?		

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM- Page 2

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: _____

MARTIN ORTHOPEDICS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Martin Orthopedics to use and/or disclose certain protected health information (PHI) about me to:

Athletic Department Staff at: Central Arkansas Christian School

This authorization permits Martin Orthopedics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Information concerning the condition and treatment of injuries sustained at school sports functions to include athletic department activities, cheerleading, drill team, band.

The information will be used or disclosed for the following purpose:

Athletic Sports Programs.

The purpose (s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire **14 months after date below.**

I do not have to sign this authorization in order to receive treatment from Martin Ortho. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practices has acted in reliance upon this authorization. This practice may in some cases receive payment for disclosing this patient's protected healthcare information. My written revocation must be submitted to Martin Orthopedics.

X _____ _____

Signature of Parent/ Legal Guardian | Relationship to Student Athlete

_____ _____

Student's Name | Date

_____ _____

Print Name of Parent/ Legal Guardian | Date of Birth of Student Athlete

Central Arkansas Christian
Medical Consent Form

CAC and its staff have permission to administer first aid to the student(s) named on this sheet as necessary. In the event of an emergency, and I cannot be reached, I give my permission to the staff of CAC to obtain whatever care is necessary for the health and well-being of my child. I agree to carry medical insurance.

It is not the responsibility of CAC to provide such coverage. I further understand that my child(ren) must have a physical exam and certain immunizations in accordance with state requirements.

Your signature verifies that you understand and agree to the statements on this page.

Student(s) _____

_____

Parent/Guardian Signature _____

Date _____