

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

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

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

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

General Questions		Yes	No	Medical Questions		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.							
1. Do you have any concerns that you would like to discuss with your provider?				16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Has a provider ever denied or restricted your participation in sports for any reason?				17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
3. Do you have any ongoing medical issues or recent illness?				18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
Heart Health Questions About You				Females Only			
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?				19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?				21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?			
7. Has a doctor ever told you that you have any heart problems?				22. Have you ever become ill while exercising in the heat?			
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.				23. Do you or someone in your family have sickle cell trait or disease?			
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?				24. Have you ever had or do you have any problems with your eyes or vision?			
10. Have you ever had a seizure?				25. Do you worry about your weight?			
Health Questions About Your Family				26. Are you trying to or has anyone recommended that you gain or lose weight?			
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?				27. Are you on a special Diet or do you avoid certain types of foods?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTs), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?				28. Have you ever had an eating disorder?			
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?							
Bone and Joint Questions				Explain a "Yes" answer here: _____			
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 game or practice?				_____			
15. Do you have a bone, muscle, ligament or joint injury that bothers you?				_____			

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 _____

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, athletic 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: _____



Parent and Student Eligibility Waiver

Student-Athlete Name (please print) _____

I understand and agree to abide by the procedures in the South Carolina High School League (SCHSL) By-Laws. To enable the SCHSL to determine the herein-named student's eligibility to participate in interscholastic athletics in the SCHSL member school, I consent to the release of any and all portions of school record files to SCHSL, of the herein-named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work in progress and/or completed, grades received, and attendance data.

Signature of Athlete _____ Date _____

Signature of Parent _____ Date _____

Clarendon County School District
Athletic Department Sports Health Form – Page 1 of 2

Please print clearly. Please do not leave any blanks (mark "n/a" as appropriate).

SCHOOL: _____

Last Name _____ First Name _____ MI _____ DOB ____/____/____
School Year _____ - _____ Grade _____ Age _____ Gender _____ CCSD Email _____
Mailing Address _____ City _____ Zip _____
Home Phone _____ Athlete's Cell Phone _____
Parent/Guardian Name _____ Cell # _____ Work# _____
Parent/Guardian Name _____ Cell # _____ Work# _____
Emergency Contact *(other than parent/guardian)* _____ Relation to Athlete _____
EC Home # _____ EC Cell# _____ EC Work # _____
Family Doctor _____ Phone _____ Family Dentist _____ Phone _____
Family Orthopedist _____ Phone _____ Preferred Hospital _____

CONCUSSION ACKNOWLEDGEMENT

I have received and understand information in some means regarding concussions and brain injury, which has informed me of the nature and risk of concussion and brain injury, including risks associated with continuing to participate in physical activity after a concussion or brain injury. I understand that any symptom(s) of concussion should be reported to my child's coach immediately, and that my child should not participate in any physical activity, driving a motor vehicle, or strenuous mental activity until evaluated for concussion and cleared by an appropriate healthcare provider (physician, athletic trainer, physician assistant, or nurse practitioner). If diagnosed with a concussion, I understand that my child must be symptom free, cleared by a licensed physician, and complete a gradual return to play protocol supervised by a qualified medical professional prior to resuming physical activity in accordance with South Carolina State Law. It is highly recommended that the clearing physician be specifically trained in the management of sports related concussion.

CONCUSSION INFORMATION

Further information regarding the recognition and management of concussion may be requested directly from the Head Athletic Trainer at your child's high school. Parents of Middle/Jr. High students may request the assistance of the High School's Athletic Trainer in securing appropriate medical care if their child exhibits the signs or symptoms of concussion.

CONSENT TO PERFORM URINALYSIS DRUG/ALCOHOL TESTING

We/I hereby consent to have a sample of my urine collected and tested for the presence of drugs/alcohol in accordance with the Clarendon County School District Student Athlete Drug Education and Testing Program. We/I have read and understand the CCSD Student Athlete Drug Education and Testing Policy and Procedures JJIE and JJIE-R. We/I understand that this testing will occur at such time(s) as provided in the Student Athlete Drug Education and Testing Policy and Procedures. We/I understand that any urine samples will be sent to a licensed medical laboratory for actual testing. We/I hereby authorize the release of such urine testing results to the athletic director, superintendent, principal, and other school officials as deemed appropriate by the district. We/I understand that these results also will be made available to me/us. We/I understand that we/I may withdraw this consent for urinalysis testing; however, we/I also understand that should I refuse testing at the time requested, I will not be permitted to participate in any athletic event until such time as we/I consent to testing. We/I hereby release the CCSD Board of Trustees and all district and school official and employees from any legal responsibility or liability for the release of such information and records as authorized by this consent.

RELEASE OF MEDICAL INFORMATION

I/We grant permission to nurses, certified athletic trainers, coaches, physicians, or those under their direction who are part of athletic injury prevention and treatment, to have access to all necessary medical information. I/We grant the school's sports medicine staff access to medical information concerning my son/daughter by a physician or their staff. Likewise, the school's sports medicine staff may release medical information to physicians' offices, coaches, nurses, administrators, and school/district faculty and staff.

**Clarendon County School District
Athletic Department Sports Health Form – Page 2 of 2**

Please print clearly. Please do not leave any blanks (mark "n/a" as appropriate).

Last Name _____ **First Name** _____ **MI** _____ **DOB** ____/____/____

HEALTH INSURANCE INFORMATION

Clarendon County School District provides insurance to students involved in any athletic program. Our insurance covers your child ONLY during a scheduled event. This includes team practice, tournaments, scrimmages, and games. If you carry medical insurance on your child, our insurance will be considered "Secondary Insurance" to your coverage. Medicaid is considered as an insurance coverage toward any accidents or injuries incurred through our athletic program. In either case, **IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN FOR ANY CHARGES THAT MAY REMAIN AFTER THE INSURANCE(S) CARRIERS HAVE PAID.** Accidents and injuries must be reported to your child's coach or athletic trainer **within 48 hours** to be eligible for coverage or if a child is taken to a hospital or doctor's office and the parent does not notify the coach, athletic trainer, or administrator, CCSD or its schools cannot be held responsible for the financial or other costs associated with injuries sustained while participating in athletics.

Insurance Provider _____ **Policy #** _____ **Group#** _____
Insurance Company Mailing Address _____ **Phone#** _____
Policy Holder's Name _____ **Relation to Athlete** _____
Policy Holder's Employer _____ **Phone** _____
Does the above named athlete receive Medicaid benefits? ____ Yes ____ No

DISTRICT ATHLETIC TRAINER INFORMATION

The Clarendon County School District Sports Medicine Team is dedicated to providing excellent medical services to athletes throughout the District. All parents should feel free to contact the Athletic Trainer should you have any health or injury related questions or concerns regarding your child's participation in athletics in Clarendon County School District. Please contact the sports medicine staff prior to scheduling any appointments for injuries sustained as a result of participation in athletics. When the Sports Medicine staff determines that advanced medical care is required, the athlete must provide written clearance from an appropriate provider prior to returning to participation. Athletic Trainers are health care professionals who collaborate with physicians. The services provided by athletic trainers comprise prevention, emergency condition, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical care. Students who want to become certified athletic trainers must earn a degree from an accredited athletic training curriculum. Accredited programs include formal instruction in areas such as injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy and physiology, therapeutic modalities, and nutrition. Classroom learning is enhanced through clinical education experiences. More than 70 percent of certified athletic trainers hold at least a Master's Degree. For more information about the education and qualifications of Athletic Trainers, visit www.nata.org.

Athletic Trainer	SCHOOL	Email	Phone
Lindsey Lloyd	East Clarendon High School		919-344-4332
Maria Player	Manning High School		910-742-5012
Sean Rape	Scott's Branch High School		256-496-0937

*By signing below, I attest that the provided information is correct and that I understand and agree to the statements above regarding Concussion Acknowledgement, Consent to Perform Urinalysis Drug/Alcohol Testing, Release of Medical Information, and Health Insurance Information. I/We commit to reporting **ALL** injuries and illnesses to the Sports Medicine Staff, especially any symptoms of possible concussion. I/We also understand that the Sports Medicine staff requires written documentation and clearance from any medical care received prior to returning to activities even if it is not the result of participation in athletics. I/We will not condone participation in any activities against medical advice or until the athlete is cleared by an appropriate medical provider (as determined by the school's sports medicine staff).*

Parent Signature _____ **Date** _____

Student Signature _____ **Date** _____

A FACT SHEET FOR High School Parents



This sheet has information to help protect your teens from concussion or other serious brain injury.

What is a concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How can I help keep my teens safe?

Sports are a great way for teens to stay healthy and can help them do well in school. To help lower your teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
 - > Work with their coach to teach ways to lower the chances of getting a concussion.
 - > Emphasize the importance of reporting concussions and taking time to recover from one.
 - > Ensure that they follow their coach's rules for safety and the rules of the sport.
 - > Tell your teens that you expect them to practice good sportsmanship at all time.
- When appropriate for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for teens to avoid hits to the head.

Talk with your teens about concussion.

Tell them to report their concussion symptoms to you and their coach right away.



How can I spot a possible concussion?

Teens who show or report one or more of the signs and symptoms listed below—or simply say they just “don’t feel right” after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs observed by parents

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to the hit, bump, or fall
- Can't recall events *after* the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets an instruction or assignment

Symptoms reported by teens

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Blurry or double vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty concentrating or remembering
- Just not “feeling right” or “feeling down”



CONCUSSIONS AFFECT EACH TEEN DIFFERENTLY.

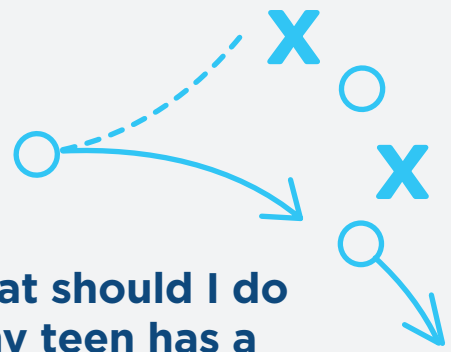
Although most teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your teens' healthcare provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities. **Be sure to offer support during their recovery and allow them to stay connected with friends and others.**

What are some more serious danger signs to look out for?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body, and can squeeze the brain against the skull. Call 9-1-1 or take your teen to the emergency department right away if after a bump, blow, or jolt to the head or body he or she has one or more of these danger signs:



- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)



What should I do if my teen has a possible concussion?

As a parent, if you think your teen may have a concussion, you should:

1. Remove your teen from play.
2. Keep your teen out of play the day of the injury. Your teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your teen's healthcare provider for written instructions on helping your teen return to school. You can give the instructions to your teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a teen for a possible concussion. You may not know how serious the concussion is at first, and some symptoms may not show up for hours or days. A teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

Teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a teen for a lifetime. It can even be fatal.

Revised August 2019

To learn more,
go to cdc.gov/HEADSUP

