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 _____

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

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. 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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Pajaro Valley High School Athletics

STUDENT INFORMATION AND EMERGENCY CONTACT CARD

Name:		Date of Birth:	
Student ID Number:	School Year:	Grade:	Graduation Year:
Home Address:			
Address line 2:			
City / State:		Zip Code:	
Sports Participating In:	Fall	Winter	Spring

List any known allergies:_____

Medications currently using:_____

Known medical conditions:_____

Insurance Carrier:_____ Policy Number:_____

_____ _____

Parent or Legal Guardian Print Name — Relationship to athlete

Best contact method (email or phone number):_____

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Emergency Contact 1

Name: _____

Relationship to Athlete:_____

Spanish speaking *only*? Please circle: YES or NO

Primary Phone number:_____

Secondary Phone Number:_____

Emergency Contact 2

Name: _____

Relationship to Athlete:_____

Spanish speaking *only*? Please circle: YES or NO

Primary Phone number:_____

Secondary Phone Number:_____

In case of injury, I hereby give my permission for the student named above to be given immediate emergency care by any physician and/or emergency services personnel. I also grant permission for the student athlete to be transported to _____ hospital or the nearest available hospital by emergency vehicle. Furthermore, I authorize any hospital which has provided treatment to the aforementioned to surrender physical custody of such minor to the above-named agent(s) upon completion of treatment.

I do hereby indemnify and hold harmless the Department and entities and other persons who act in reliance upon this authorization.

_____ _____

Parent/legal guardian signature — Date

Pajaro Valley High School Athletics

ACKNOWLEDGMENT OF RISK AND INFORMED CONSENT FOR INTERSCHOLASTIC ATHLETIC PARTICIPATION

Student Name: _____ Student ID #:_____ School year:_____

Parent/Legal Guardian: Read the following statements concerning participation in the Pajaro Valley High School (PVHS) interscholastic athletic program. A parent/legal guardian is required to review the following information and acknowledge by initialing after each section.

Consent to Participate: I, _____, the parent/legal guardian, give consent for the above named student-athlete to participate in interscholastic athletics as provided by Pajaro Valley High School and represent the school as a team member in accordance with the policies and conditions set forth by the school district, school administration, and coaches.

Initial: _____

List any sports that consent is **NOT** given for the named student-athlete:

_____

Acknowledgement and Assumption of Injury Risk:

I, the parent/legal guardian, and the above named student athlete acknowledge that preparation for and participation in interscholastic athletics involves a risk of serious and permanent injury to a student athlete. I understand that these risks can arise at any time during athletic participation and include, but are not limited to, death or paralysis, brain damage, cardiac arrest, serious injury to internal organs and/or bones, joints, ligaments, muscles, tendons, and other serious injury or impairment to other aspects of the athlete's health and well-being. With this, I release and forever discharge Pajaro Valley High School and its past, present, and future officers, directors, partners, shareholders, members, managers, agents, employees, successors, subsidiaries, parents, representatives, attorneys, affiliates, heirs and insurers, from any and all liability, loss, damages, costs, claims, and/or causes of actions resulting from any accident, illness, bodily harm, personal injury, death, and/or property loss, however caused from or in any way related to participation in athletics at Pajaro Valley High School, including such risks and dangers caused in whole or in part from negligence of Pajaro Valley High School and/or its employees, agents, and representatives.

Because of the dangers of participating in interscholastic sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, and other team rules, as well as obeying such instructions.

I hereby acknowledge and agree that there are certain risks and dangers associated with participating in athletics at Pajaro Valley High School, including risks of illness, serious injury, and death; and I knowingly and voluntarily accept and assume responsibility for such risks.

Initial: _____

Insurance: Accident and health insurance is a requirement, prior to tryout, practice, or participation in interscholastic athletics and must remain active throughout the entire school year. Maintaining said policy in force shall be a parent/legal guardian responsibility. Insurance may be purchased from a private carrier or through the school insurance program.

Initial: _____

Name of Insurance Carrier: _____ **Policy Number:** _____

Pajaro Valley High School Athletics

ACKNOWLEDGMENT OF RISK AND INFORMED CONSENT FOR INTERSCHOLASTIC ATHLETIC PARTICIPATION

Student Name: _____ Student ID #:_____ School year:_____

Financial Responsibility for Medical Care: It is agreed financial responsibility for securing care of athletic injuries is a matter between the parent/legal guardian and the health care provider. PVHS will not be liable for payment of health care providers for the treatment of the named student-athlete. I hereby indemnify and hold harmless Pajaro Valley High School from any and all claims, demands, lawsuits, liabilities, damages, expenses (including reasonable attorney fees), and/or costs arising out of or related to participation in athletics at Pajaro Valley High School.

Initial: _____

Physical Examinations: A pre-participation physical exam is required annually for all students who wish to participate in tryouts, practices, or competitions. Physical exams for FALL sports (Football, Cheer, Tennis, Cross Country, or Girls' Volleyball) must be dated **DECEMBER 1 or later,** for WINTER Sports (Soccer, Basketball, or Wrestling) must be dated **JANUARY 1 or later,** and for SPRING sports (Boys' Volleyball, Track and Field, Softball, or Baseball) must be dated **MAY 1 or later** for it to be valid for the following school year. Athletic physicals dated **prior** to the above dates of a calendar year will not be valid upon the starting date for sports in the following year.

Initial: _____

Notification of Injuries: Information regarding the care, disposition, and treatment of athletic injuries will be shared only with student-athlete's high school athletic trainer, school athletic director, treating physician, team physician, school nurse, and/or team coach as applicable and on a need to know basis for the time the student-athlete is participating in PVHS athletics. Information released to a third party by school health care providers may only occur with written permission of the parent/legal guardian. I give permission for medical information to be released and discussed with the certified athletic trainer, school nurse, team coaches, athletic administrators, parents and/or guardians if reasonably necessary to provide the best care possible.

Initial: _____

Transportation Responsibilities: It is agreed that the parent/legal guardian and student will assume the legal responsibilities for personal safety and action of the named student while traveling to and from practices and competitions when transportation is not provided by the PVHS. When transportation is provided by PVHS, policy requires student-athletes to use such transportation to and from practices and competitions. Any exceptions must be arranged with and approved by the school athletic director/school administration prior to the departure and in accordance with established travel policies.

Initial: _____

Emergency Transportation: I understand that in the event of an emergency, medical transportation may be required. I also understand that in some situations, transport to a hospital may be necessary but Emergency Medical Services may not be needed or may take too long to arrive; in the rare occasion that EMS is not available or transportation will be quicker by personal vehicle, I understand that a coach, administrator, or available parent may be the quickest transportation option available.

In the event that I am not available, I hereby grant permission for the above named student-athlete to be transported to the nearest hospital by emergency vehicle or designated PVHS personnel including coaches, administrators, or available parents.

Initial: _____

CIF Concussion Information Sheet

Why am I getting this information sheet?

You are receiving this information sheet about concussions because of California state law AB 25 (effective January 1, 2012), now Education Code § 49475:

1. *The law requires a student-athlete who may have a concussion during a practice or game to be removed from the activity for the remainder of the day.*
2. *Any student-athlete removed for this reason must receive a written note from a physician trained in the management of concussion before returning to practice.*
3. *Before a student-athlete can start the season and begin practice in a sport, a concussion information sheet must be signed and returned to the school by the student-athlete and the parent or guardian.*

[Every 2 years all coaches are required to receive training about concussions (AB 1451), sudden cardiac arrest (AB 1639), and heat illness (AB 2500), and certification in First Aid training, CPR, and AEDs (life-saving electrical devices that can be used during CPR)].

What is a concussion and how would I recognize one?

A concussion is a kind of brain injury. It can be caused by a bump or hit to the head, or by a blow to another part of the body with the force that shakes the head. Concussions can appear in any sport, and can look differently in each person.

Most concussions get better with rest and over 90% of athletes fully recover. However, all concussions should be considered serious. If not recognized and managed the right way, they may result in problems including brain damage and even death.

Most concussions occur without being knocked out. Signs and symptoms of concussion (see back of this page) may show up right after the injury or can take hours to appear. If your child reports any symptoms of concussion or if you notice some symptoms and signs, seek medical evaluation from your team's athletic trainer and a physician trained in the evaluation and management of concussion. If your child is vomiting, has a severe headache, or is having difficulty staying awake or answering simple questions, call 911 for immediate transport to the emergency department of your local hospital.

On the CIF website is a ***Graded Concussion Symptom Checklist.*** If your child fills this out after having had a concussion, it helps the physician, athletic trainer or coach understand how they are feeling and hopefully will show improvement over time. You may have your child fill out the checklist at the start of the season even before a concussion has occurred so that we can understand if some symptoms such as headache might be a part of their everyday life. We call this a "baseline" so that we know what symptoms are normal and common for your child. Keep a copy for your records, and turn in the original. If a concussion occurs, your child can fill out this checklist again. This Graded Symptom Checklist provides a list of symptoms to compare over time to follow your child's recovery from the concussion.

What can happen if my child keeps playing with concussion symptoms or returns too soon after getting a concussion?

Athletes with the signs and symptoms of concussion should be removed from play immediately. There is NO same day return to play for a youth with a suspected concussion. Youth athletes may take more time to recover from concussion and are more prone to long-term serious problems from a concussion.

Even though a traditional brain scan (e.g., MRI or CT) may be "normal", the brain has still been injured. Animal and human research studies show that a second blow before the brain has recovered can result in serious damage to the brain. If your athlete suffers another concussion before completely recovering from the first one, this can lead to prolonged recovery (weeks to months), or even to severe brain swelling (Second Impact Syndrome) with devastating consequences.

There is an increasing concern that head impact exposure and recurrent concussions may contribute to long-term neurological problems. One goal of concussion education is to prevent a too early return to play so that serious brain damage can be prevented.

Signs observed by teammates, parents and coaches include:	
• Looks dizzy • Looks spaced out • Confused about plays • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or awkwardly • Answers questions slowly	• Slurred speech • Shows a change in personality or way of acting • Can't recall events before or after the injury • Seizures or "has a fit" • Any change in typical behavior or personality • Passes out

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or throws up • Neck pain • Has trouble standing or walking • Blurred, double, or fuzzy vision • Bothered by light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Loss of memory • "Don't feel right" • Tired or low energy • Sadness • Nervousness or feeling on edge • Irritability • More emotional • Confused • Concentration or memory problems • Repeating the same question/comment

What is Return to Learn?

Following a concussion, students may have difficulties with short- and long-term memory, concentration and organization. They may require rest while recovering from injury (e.g., limit texting, video games, loud movies, or reading), and may also need to limit school attendance for a few days. As they return to school, the schedule might need to start with a few classes or a half-day. If recovery from a concussion is taking longer than expected, they may also benefit from a reduced class schedule and/or limited homework; a formal school assessment may also be necessary. Your school or physician can help suggest and make these changes. Students should complete the Return to Learn guidelines, successfully returning to a full school day and normal academic activities, before returning to play (unless your physician makes other recommendations). Go to the CIF website (cifstate.org) for more information on Return to Learn.

How is Return to Play (RTP) determined?

Concussion symptoms should be completely gone before **returning to competition**. A RTP progression is a gradual, step-wise increase in physical effort, sports-specific activities and then finally unrestricted activities. If symptoms worsen with activity, the progression should be stopped. If there are no symptoms the next day, exercise can be restarted at the previous stage.

RTP after concussion should occur only with medical clearance from a physician trained in the evaluation and management of concussions, and a step-wise progression program monitored by an athletic trainer, coach, or other identified school administrator. Please see cifstate.org for a graduated return to play plan. *[AB 2127, a California state law effective 1/1/15, states that return to play (i.e., full competition) must be **no sooner** than 7 days after the concussion diagnosis has been made by a physician.]*

Final Thoughts for Parents and Guardians:

It is well known that students will often not talk about signs of concussions, which is why this information sheet is so important to review with them. Teach your child to tell the coaching staff if they experience such symptoms, or if they suspect that a teammate has had a concussion. You should also feel comfortable talking to the coaches or athletic trainer about possible concussion signs and symptoms that you may be seeing in your child.

References:
- *American Medical Society for Sports Medicine position statement: concussion in sport (2013)*
- *Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Berlin, October 2016*
- *https://www.cdc.gov/traumaticbraininjury/PediatricmTBIGuideline.html*
- *https://www.cdc.gov/headsup/youthsports/index.html*

Please detach, sign, and turn this sheet in to the Athletic Trainer

I have read and understood this document the "Student/Parent Awareness and Consent Form" and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: _____

Student signature: _____

Student ID number: _____

Date: _____

Parent/Guardian name: _____

Parent/Guardian signature: _____

Date: _____

----------Contact Sport Athletes ONLY----------

Baseline evaluations will be conducted prior to the start of the sport season and will include cognitive and balance testing for all athletes participating in contact and high-risk sports.

Required baseline: Football, Flag football, Volleyball (girls/boys), Cheer, Soccer (girls/boys), Basketball (girls/boys), Wrestling (girls/boys), Softball, Baseball, T&F- throwers, jumpers

I have completed the necessary concussion baseline assessments.

Sway Baseline Assessment
Date:
Student signature:
Student ID #:
Athletic Trainer: