

# Preparticipation Physical Evaluation

# HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_

**In case of emergency, contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

		Yes	No			Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
				<b>FEMALES ONLY</b>			
				47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
				48.	How old were you when you had your first menstrual period? _____		
				49.	How many periods have you had in the last 12 months? _____		
				<b>Explain "Yes" answers here:</b> _____			
				_____			
				_____			
				_____			

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 \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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Sherrri A. Freeman  
Principal

# Houston County High School

920 Highway 96  
Warner Robins, Georgia 31088  
(478) 988-6340  
Fax (478) 988-6341

*Our mission is to provide quality learning experiences, enabling our graduates to meet tomorrow's challenges.*

*Our vision is to be globally competitive in academics, the arts, athletics, and service to the community.*

Amy Barbour  
Brian Christensen  
Mortimer Floyd  
Andrea Jordan  
Todd Pryby  
William Ray  
**Assistant Principals**  
Greg Robinson  
**Athletic Director**

**2009/2010**

## PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

**WARNING:** Although participation in supervised inter-scholastic athletics and activities may be one of the least hazardous in which students will engage, in or out of school, **BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT 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, the risk.

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

By signing this permission form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I (We) hereby give consent for my child, \_\_\_\_\_, to:

1. Compete in athletics at Houston County High School of the Houston County School District in the Georgia High School Association approved sports circled below:  

Baseball	Basketball	Cheerleading	Cross Country	Football
Golf	Soccer	Softball	Swimming	Tennis
Track	Wrestling	_____		
2. Accompany any school team of which he/she is a member on any of its local or out-of-town trips;

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parents/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

E-Mail Address \_\_\_\_\_



A Recognized School of Excellence



Sherri A. Freeman  
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**2009 / 2010**

## **INSURANCE WAIVER AND VERIFICATION FORM**

Student Name: \_\_\_\_\_

All students in the Houston County School System must show proof of insurance in order to participate in any athletic activity. If the student's parents do not have coverage, Houston County can provide various coverage at modest cost. These coverages will be made available to any interested persons.

It is important that you understand that this policy is an excess policy and that your own family or company policy must pay first.

I hereby relieve the Houston County Board of Education and Houston County High School Athletic Department and its employees of any financial responsibility or liability for injuries which may occur during the practice, competition, or travel to or from athletic events and/or contests.

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

GUARANTOR \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

E-MAIL \_\_\_\_\_



A Recognized School of Excellence

## PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of the Houston Healthcare Complex Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Representative

Please describe the Representative's authority to act on behalf of Patient (initial one):

- The representative is the parent of the patient, who is a minor.
- The representative is the guardian of the patient, who has been adjudicated incompetent.
- The representative is acting under a Durable Power of Attorney for Health Care for the Patient, and has presented a copy of this document to Complex personnel.

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### FOR COMPLEX USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it:

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**AUTHORIZATION FOR MEDICAL EXAMINATION  
AND TREATMENT**

Student Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

My child, identified above, participates in the athletic program at:

\_\_\_\_\_  
(Name of School)

During my child's participation in the athletic programs of the school listed above, I understand that he/she will be under the care of certified athletic trainers who are provided by Houston Healthcare. I do hereby consent to any examination, medical care and/or treatment deemed medically necessary or appropriate by the team physician, athletic trainer or coach.

This consent to treatment is granted pursuant to the provisions of the Georgia Medical Consent Law, Official Code of Georgia Annotated, Title 31, Chapter 9 and shall be construed in accordance with that statute.

This authorization covers the school year: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name