Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ 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

EMERGENCY INFORMATION

Allergies _____

Other information _____

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

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 _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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 _____

RICHMOND HILL HIGH SCHOOL
ATHLETIC EMERGENCY INFORMATION

NAME **SPORT(S)**

SOCIAL SECURITY NUMBER **AGE** **GRADE** **DATE OF BIRTH**

NAME OF PARENT/GUARDIAN

HOME TELEPHONE NUMBER

EMERGENCY TELEPHONE NUMBER **(CANNOT BE HOME TELEPHONE NUMBER)**

PHYSICIAN'S NAME **PHONE NUMBER**

PRIMARY INSURANCE COMPANY **POLICY NUMBER**

SECONDARY INSURANCE COMPANY **POLICY NUMBER**

HMO **POLICY NUMBER**

SPECIAL MEDICAL CONDITIONS **(PLEASE SPECIFY NECESSARY TREATMENT)**

THIS INFORMATION SHEET WILL BE KEPT ON FILE BY YOUR CHILD=S COACH IN THE EVENT EMERGENCY TREATMENT IS NEEDED.

PARENT/GUARDIAN SIGNATURE **DATE**

BRYAN COUNTY SCHOOLS
RELEASE FORM FOR ATHLETIC ACTIVITIES
REQUIRING SYSTEM TRANSPORTATION

STUDENT NAME: _____ **GRADE:** _____

INSURANCE INFORMATION

Policy (Company) Name _____ *Policy/Group Number:* _____

Name of Insured _____

MEDICAL INFORMATION

The following information will be provided to EMS personnel, physician(s), and other health care personnel as needed in the event your child needs assistance and you cannot be located. I/We, the parent(s) of _____*, hereby give EMS personnel, physician(s) and other health care personnel to render medical treatment to the child in case of illness or injury. I further authorize you to transport the child to the* _____*Hospital and/or the family physician,* _____ *(Phone)* _____*. If the family physician cannot be contacted., I authorize the emergency room physician to treat the child. I hereby release the Bryan County Board of Education and its employees and agents from all claims arising from such treatment or care.*

MY CHILD HAS THE FOLLOWING MEDICAL CONDITIONS OF WHICH YOU SHOULD BE AWARE IN PROVIDING HEALTH TREATMENT: _____

_____

MY CHILD HAS AN ALLERGY TO THE FOLLOWING MEDICATION(S): _____

_____

****I HAVE PROVIDED RHHS WITH A COPY OF MY INSURANCE CARD TO HAVE ON FILE IN THE SCHOOL OFFICE WITH MY CHILDS ATHLETIC FORMS.**

_____
Parent/Guardian Signature

_____
Date

****Parents, please note the above referenced.**

NONDISCRIMINATION STATEMENT

It is the policy of the Bryan County Board of Education not to discriminate on the basis of sex, age, race, handicap, disability, religion, or national Origin in the educational programs and activities or in admission to facilities operated by the Bryan County Board of Education or in the employment practices of the Bryan County School System. The Bryan County Board of Education complies with all aspects of Title IX of the Education Amendments of 1972. Title VI of the Civil Rights Act of 1964 (Amended, 1973), Title II of Vocational Education Amendments of 1976, Title VII of the Civil Rights Act of 1964 (Amended, 1974), Title XXIX of the Age Discrimination Act of 1967, Section 504 of the Rehabilitation Act of 1973, and the Americans With Disabilities Act.

RICHMOND HILL HIGH SCHOOL

HEAT POLICY

Dear Parents/Guardians,

GHSA has implemented a new heat policy guideline to help aid the safety of your child during participation in school sports. Coaches, Athletic Trainers, and Administrators will be enforcing these rules and guidelines in full effect.

Please sign below stating that you have been presented and read over the new heat policy guideline that Richmond Hill High School will be enforcing. If you have any questions or concerns, do not hesitate to ask.

Thank You!

Signature: _____

Print Name: _____

Son/Daughter's Name: _____

Date: _____

REMEMBER TO PROVIDE STUDENT INSURANCE VERIFICATION WITH COMPLETED PHYSICAL PACKET

COPY OF INSURANCE CARD OR PRINTED INSURANCE VERIFICATION

RICHMOND HILL HIGH SCHOOL
HEAT POLICY

Parents,

GHSA has implemented a new heat policy guideline to help aid the safety of your child during participation in school sports. Coaches, Athletic Trainers, and Administrators will be enforcing these rules and guidelines in full effect. Below are the GHSA's guidelines. Richmond Hill High School will be going above and beyond to ensure the safety of your child. A scientifically approved instrument that measures Wet Bulb Globe Temperature (WBGT) reading will be utilized at each practice to ensure that the written policy is being followed properly. Please look over the guidelines and if you have any questions, don't hesitate to ask.

1. BY-LAW 2.67 – "Practice Policy for Heat and Humidity

GUIDELINES FOR HYDRATION AND REST BREAKS

1. Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity involved
2. For football, helmets should be removed during rest time
3. The site of the rest time should be a "cooling zone" and not in direct sunlight.
4. When the WBGT reading is over 86:
    a. Ice towels and spray bottles filled with ice water should be available at the "cooling zone" to aid the cooling process.
    b. Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

PENALTIES: Schools violating the heat policy shall be fined a minimum of $500.00 and a maximum of $1,000.00.

REMEMBER TO PROVIDE STUDENT INSURANCE VERIFICATION WITH COMPLETED PHYSICAL PACKET

COPY OF INSURANCE CARD OR PRINTED INSURANCE VERIFICATION

WBGT READING	ACTIVITY GUIDELINES & REST BREAK GUIDELINES
UNDER 82.0	Normal activities --Provide at least three separate rest breaks each hour of minimum duration of 3 minutes each during workout.
82.0 – 86.9	Use discretion for intense or prolonged exercise; watch at-risk players carefully; Provide at least three separate rest breaks each hour of a minimum of four minutes duration each.
87.0 – 89.9	Maximum practice time is two hours. For Football: players restricted to helmet, shoulder pads, and shorts during practice. All protective equipment must be removed for conditioning activities. For all sports: Provide at least four separate rest breaks each hour of a minimum of four minutes each.
90.0 – 92.0	Maximum length of practice is one hour, no protective equipment may be worn during practice and there may be no conditioning activities. There must be 20 minutes of rest breaks provided during the hour of practice.
OVER 92.0	No outdoor workouts; Cancel exercise; delay practices until a cooler WBGT reading occurs.

DEFINITIONS

1. **PRACTICE:** the period of time that a participant engages in a coach-supervised, school-approved sport or conditioning-related activity. Practices are timed from the time the players report to the field until they leave.

2. **WALK THROUGH*:*** this period of time shall last no more than one hour, is not considered to be a part of the practice time regulation, and may not involve conditioning or weight-room activities. Players may not wear protective equipment.