#### **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			
	choolSport(s)					
			edicines and supplements (herbal and nutritional) that you are currently			
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens			ergy below.  ☐ Food  ☐ Stinging insects			
Explain "Yes" answers below. Circle questions you don't know the an			MEDICAL QUESTIONS	V		
GENERAL QUESTIONS	Yes	No	26. Do you cough, wheeze, or have difficulty breathing during or	Yes	No	
Has a doctor ever denied or restricted your participation in sports for any reason?			after exercise?			
Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?	-		
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			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	<u> </u>		
Have you ever spent the night in the hospital?			(males), your spleen, or any other organ?			
Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?			
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?			
Have you ever passed out or nearly passed out DURING or     AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin problems?			
6. Have you ever had discomfort, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?		ļ	
chest during exercise?			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.		ļ	
7. Does your heart ever race or skip beats (irregular beats) during exercise?			prolonged headache, or memory problems?			
Nas a doctor ever told you that you have any heart problems? If so, check all that apply:			36. Do you have a history of seizure disorder?			
☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?			
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		_	39. Have you ever been unable to move your arms or legs after being hit or falling?			
10. Do you get lightheaded or feel more short of breath than expected		-	40. Have you ever become ill while exercising in the heat?			
during exercise?	<u> </u>	ļ	41. Do you get frequent muscle cramps when exercising?			
11. Have you ever had an unexplained seizure?		ļ	42. Do you or someone in your family have sickle cell trait or disease?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?			43. Have you had any problems with your eyes or vision?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries? 45. Do you wear glasses or contact lenses?			
13. Has any family member or relative died of heart problems or had an			46. Do you wear grasses or contact tenses?  46. Do you wear protective eyewear, such as goggles or a face shield?			
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		· · · · · · · · · · · · · · · · · · ·	
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?			
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			49. Are you on a special diet or do you avoid certain types of foods?			
polymorphic ventricular tachycardia?			50. Have you ever had an eating disorder?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		ļ	
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY	ļ	1.1414	
seizures, or near drowning? BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period?   53. How old were you when you had your first menstrual period?	-	<u> </u>	
17. Have you ever had an injury to a bone, muscle, ligament, or tendon	163	140	54. How many periods have you had in the last 12 months?	<u> </u>		
that caused you to miss a practice or a game?			Explain "yes" answers here	J		
18. Have you ever had any broken or fractured bones or dislocated joints?		ļ				
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?						
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?		ļ				
23. Do you have a bone, muscle, or joint injury that bothers you?	ļ	ļ				
24. Do any of your joints become painful, swellen, feel warm, or look red?     25. Do you have any history of juvenile arthritis or connective tissue disease?						
I hereby state that, to the best of my knowledge, my answers to	the abo	ve que	stions are complete and correct.			
Signature of athlete Signature						
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#### 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)		Ann and the state of the state	
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Parent/Guardian Signature			
Date		and health at the second at th	

# **■ PREPARTICIPATION PHYSICAL EVALUATION**

## PHYSICAL EXAMINATION FORM

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History approach price (algorithms, christering bilancous, surful, or dign?						
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Policy   P	EXAMINATION					
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- Hearting						
Lymph nodes					•	
Heart*  - Mammurs (quasculation standing, supine, +/- Valsalvea)  - Location of point of maximal impulse (PMM)  - Paters  - Shinullanoous femoral and radial pobles  - Shouldanoous femoral and radial pobles  - Shinullanoous femoral and radial pobles  - Shouldanoous femoral and radial pobles  - Histly, Issuins suppestive of MRSA, tinea corporis  -					***	
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