BRANDON VALLEY PHYSICAL FORM

STEP 1	COMPLETE THE BOTTOM OF PAGE 1. (PARENT/GUARDIAN AND STUDENT SIGNATURES ARE REQUIRED.)
STEP 2	COMPLETE PAGE 2.
STEP 3	GIVE THE FORM TO THE DOCTOR TO COMPLETE THE TOP OF PAGE 1.
STEP 4	SUBMIT COMPLETED PAGES 1 AND 2 TO THE HIGH SCHOOL OR MIDDLE SCHOOL OFFICE.

2024-2025 ANNUAL PHYSICAL EXAMINATION FORM

SUBMIT COMPLETED PAGES 1 AND 2.

Exam must be dated on or after April 1, 2024, to qualify for the 2024-2025 school year.

STUDENT NAME: ______________________ **GRADE** ______ (Fall of 2024)

DATE OF BIRTH: ______________ **DATE OF EXAM:** ______________ **MALE** ___ **FEMALE** ___

EXAMINATION		
Height:	Weight:	BP:
Pulse:	Vision: R 20/ L 20/	Corrected?:

MEDICAL	Normal	Abnormal Findings
Appearance		
Head/Mouth		
Eyes, ears, nose, and throat — Pupils equal and Hearing		
Lymph Nodes		
Heart* — Heart sounds, murmurs, pulse, rhythm, auscultation		
Lungs		
Abdomen — Liver/Spleen, masses		
Skin — HSV, Lesions, Staphy, MRSA, etc.		
Neurological		

MUSCULOSKELETAL	Normal	Abnormal Findings
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, Hand and Fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional — Double-leg squat test, single-leg squat test, box drop or step-drop test		

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, e-cigarettes, vaping, chewing tobacco, snuff or dip?
- Over the past 30 days, have you used 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-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seatbelt or helmet?

2. Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)

** Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination.*

SPORTS PARTICIPATION RECOMMENDED FOR (mark one):

☐ Medically eligible for ALL sports without restriction

☐ Medically eligible for ALL sports without Restriction with recommendation for further evaluation or treatment of ______________

☐ Medically eligible CERTAIN sports (list here): ______________

☐ **Not medically eligible pending further evaluation:** ______________ ☐ **Not medically eligible for ANY sports**

NAME OF EXAMINER:______________ **DATE OF EXAM** __________ **20**_____

SIGNATURE OF EXAMINER (stamp not accepted)______________

NOTE: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physicians Assistant and Licensed Nurse Practitioners as those who can provide this recommendation. Form adapted with permission © 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, 2019.

PARENT/GUARDIAN AND STUDENT:

REVIEW, SIGN, AND DATE BELOW — AND SUBMIT COMPLETED PAGES 1 AND 2.

We have read and agree to ALL statements in the following online documents: Concussion Facts; HIPPA; and the SDHSAA Consent for Participation and Treatment. We have ALSO completed the ANNUALLY REQUIRED Family Access (FA) verification process for THE 2024-2025 YEAR OR WILL complete it when it becomes available. (Until the FA verification is complete, existing information, including emergency info, will be used, AND ALL permissions -- including permission to print student information used for travel, rosters, and media coverage -- will be assumed.) We also agree to all SDHSAA/BVSD rules for participation (links under Activities on the BVHS website).

PARENT (or GUARDIAN) Signature	DATE	STUDENT Signature	DATE

PRE-PARTICIPATION HEALTH HISTORY FORM

SUBMIT COMPLETED VERSION OF THIS PAGE AND PAGE 1 TO THE SCHOOL OFFICE.

PRIOR TO ACTIVITY PARTICIPATION, SUBMIT A COMPLETED VERSION OF THIS PAGE AND PAGE 1 TO THE BVHS OR BVMS OFFICE.

Student Name: ______________________ **Parent Name**: ______________________

Student Date of Birth: ____________ **Grade (Fall of 2024):** ________ **Date of Exam**: ________ **Sport(s):** ______________

List all past and current medical conditions:

Have you ever had surgery? If yes, please list all procedures:

Do you take any medications or supplements? PLEASE CIRCLE: Yes or No If Yes, list all prescriptions, over-the-counter meds or supplements you currently take:

Do you have any allergies? PLEASE CIRCLE: Yes or No If Yes, please list allergies here:

Over the last two weeks, how often have you been bothered by the following? (Circle Response on right:)	Not At All	Several Days	Over 1/2 the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest in pleasure or doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes.

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR" AND EXPLAIN ANY YES ANSWERS BELOW.

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? (Examples: electrocardiography and echocardiography.)		
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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 crash)?		
12. Does anyone in your family have a genetic heart problem, such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CVPT)?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
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 practice or a game?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, tingling, or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
29. Have you ever had COVID-19?		
FEMALES ONLY	**Yes**	**No**
30. Have you ever had a menstrual period? 31. How old were you when you had your first period? ____________ 32. When was your most recent menstrual period? ____________ 33. How many periods have you had in the past 12 months? ____________		

EXPLAIN ANY "YES" ANSWERS HERE AND ON SEPARATE SHEET (IF NEEDED): ______________________

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CERTIFICATION OR RE-CERTIFICATION OF HEALTH: By signing page 1 of this form, we state that, to the best of our knowledge, all answers on this page are complete and correct AND that the above-named student is physically fit to participate in interscholastic athletics for the current school year, including those areas marked 'yes' above.

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