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.**

Brandon Valley Schools

PHYSICAL EXAMINATION FORM
(2018-2019)

SUBMIT COMPLETED PAGES 1 AND 2.

NAME _____ **GRADE** _____(Fall of 2018)

DATE OF BIRTH_____ **PLACE OF BIRTH** _____ **MALE** _____ **FEMALE** _____

1. Blood pressure (sitting) _____/_____ Repeat in 5 minutes, if elevated _____/_____
2. Height _____
3. Weight _____

	Normal	Abnormal	Comments
4. Vision 20/_____(L) 20/_____(R)			
5. Head			
6. Mouth (dentures, braces?)			
7. Eyes (contacts?)			
8. Chest/lung			
9. Heart			
a. Heart sounds			
b. Murmurs			
c. pulse discrepancy (rad. vs fem.)			
d. abnormal rhythm			
10. Abdomen			
a. liver or spleen enlargement			
b. masses			
11. Genitalia (males only)			
a. hernias			
b. testes			
12. Orthopedic			
a. cervical spine			
b. shoulder shrug			
c. deltoid			
d. arms/elbow			
e. hands			
f. hips			
g. knees			
h. ankles			
i. Scoliosis			

SPORTS PARTICIPATION RECOMMENDED FOR:

_____All Sports: Collision, Contact/Endurance and Other _____Contact/Endurance and Other _____Other Sports Only

_____Cleared for ALL, but with recommendations for further evaluation or treatment for _____

_____Above clearance to be granted only after _____

_____**Clearance cannot be given at this time because** _____

Sport Definitions: Collision = Football, Wrestling. Contact/Endurance = Baseball, Basketball, Cheer, Cross Country, Dance, Powerlifting, Soccer, Softball, Tennis, Track and Volleyball. Other Activities = Bowling, Golf, Marching Band

PRINTED NAME OF EXAMINER:_____ DATE_____ 20_____

SIGNATURE OF EXAMINER_____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physicians Assistant and licensed Nurse Practitioner.

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 Concussion Facts, Medical Info and SDHSAA Annual Parent/Student Consent form (on Web site). We have ALSO read and agree to all statements in the online HIPPA form. We will ALSO complete the required Family Access (FA) verification process for THE 2018-19 YEAR when the verification process becomes available in August. (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 team travel, rosters, and standard media coverage -- will be assumed.)

PARENT (or GUARDIAN) Signature	DATE	STUDENT Signature	DATE

PRE-PARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

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

(Note: This form is to be filled out by the patient and parent/guardian prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam: _____ **Student Name:** _____

Parent Name: _____ **Student Date of Birth:** _____ **Student Place of Birth:** _____

Gender: _____ **Age**: _____ **Grade (2018-19 school year):** _____**School:** _____ **Sport (s):** _____

Medications and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

_____

_____

Do you have allergies? ☐ Yes ☐ No **If yes, please identify allergy below:**

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" to the answers below. Circle questions you don't know 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	**Yes**	**No**
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 in this space. Also List all precautions (allergies, diseases, medications, etc.) that should be considered in treating the above named student:

_____

_____

_____

_____

_____

_____

By signing page 1 of this form, we — the parent/guardian and student — state that, to the best of our knowledge, our answers to the above questions are complete and accurate.