■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Gender (Male or Female): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? ***(check box next to appropriate number)***

	Not at all	Several days	Over half 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 or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would 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 illness?	☐	☐
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? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed 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 years (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 (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an 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 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 (males), 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 any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (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, had tingling, had 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?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
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?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ 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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Consent to Treat-- I hereby give permission for my child, _____, to receive medical attention from a physician or allied health care provider as deemed appropriate by First Presbyterian Day School in the event of illness or injury.

➢ _____ _____

Signature of parent or legal guardian Date

Assumption of Risk-First Presbyterian Day School, in accordance with the rules and regulations of the Georgia Independent Athletics Association, covers its students with a catastrophic insurance policy. Any claim on this policy must meet the minimum $25,000 deductible. In consideration of the right to participate in athletic activities, I do hereby assume for my son/daughter all risks involved in such activities and in transporting him/her from the same; and I will hold FPDS harmless from any and all liability, action, debts, claims, demands of every kind and nature whatsoever which may arise. The terms hereof will serve as a release and assumption of risks and liability for my son/daughter.

➢ _____ _____

Signature of Parent or legal guardian Date

Over the Counter Medications--Below is a list of medications that are usually kept in stock. Medications will be dispensed on an as needed basis in single doses as recommended by the product labels or as directed by a physician. Your initials in the yes box will indicate your permission to dispense that specific medication to your child. If your child **may not** have a particular medication, please initial the no box.

Medication	**YES**	**NO**
NSAID's [Ibuprofen or Naproxen Sulfate]		
Pain Reliever [Acetaminophen]		
Electrolyte Tablet		
Pepto Bismol or equivalent		
Anti-acid tablet		
Topicals [Antibiotic, hydrocortisone, antifungals, Styptic, Sting relief, etc.		

I hereby give permission for the above named child to receive over the counter medications as indicated above.

➢ _____ _____

Signature of Parent or legal Guardian Date

GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

STUDENT / PARENT CONCUSSION AWARENESS FORM

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a State Law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GIAA Athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level / tiredness.
- Nausea or vomiting.
- Blurred vision, sensitivity to light and sounds.
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments.
- Unexplained changes in behavior and personality.
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

GIAA Concussion Policy: If a Coach observes a Student-Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student-Athlete from practice, conditioning, or game. The Student-Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student-Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student-Athlete has suffered a concussion, the Student-Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student-Athlete return to practice, conditioning, or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out

By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME: First Presbyterian Day School

STUDENT'S NAME:_____ (PRINTED) STUDENT'S SIGNATURE:_____

PARENT'S NAME:_____ (PRINTED) PARENT'S SIGNATURE:_____

DATE SIGNED:_____

GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM

LEARN THE EARLY WARNING SIGNS

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.
- Unusual chest pain or shortness of breath during exercise.
- Family members who had sudden, unexplained and unexpected death before age 50.
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome.
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.

LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST

If you see someone collapse, assume they have experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (seizure-like activity). Call for help and start CPR. You cannot hurt them.

LEARN HANDS-ON CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it is easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED).
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this Sudden Cardiac Arrest Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME: First Presbyterian Day School

STUDENT'S NAME:_____ (PRINTED) STUDENT'S SIGNATURE:_____

PARENT'S NAME:_____ (PRINTED) PARENT'S SIGNATURE:_____

DATE SIGNED:_____

Directions to add an athlete account to ATS:

1. Go to **fpdmacon2.atsusers.com** in any web browser.
2. Login in using: athlete id = **new** and the password = **new**
3. Select a team for your child. Up to 3. (FPD can change this later if needed. If you don't know use Coed FPD student only)
4. Input all available info including email (school email if possible), Cell #, text address, and additional address if parents do not live together.
5. Athlete ID should be first initial, last name, 2 digit graduation year. For Example, if John Doe Graduates in year XX, his ID should be JDoeXX
6. Select a password that the child can remember. I can change or reset this later if needed.
7. If your child has any medical alerts, allergies, or everyday needed medicines you would input that on this page.
8. Click save athlete information at the bottom of the page. When you have saved the athlete information new tabs will appear above.

Medical History

1. You can add information about recent surgeries or significant medical history

Immunizations/paperwork

1. This is not necessary for set up purposes.

Insurance

1. This is optional. FPD does not bill for services rendered through the athletic training facility. You may need to add your insurance company first, but you can add a child's insurance information which may help with making appointments and is convenient if the child ends up at a hospital.

Contacts

1. Add emergency contacts here. Start with all parents. Then add at least two non-parent emergency contacts.

eFiles (If you do not have an FPD issued tablet or a touch sensitive screen)

1. Download the PPE form and complete it and have a doctor complete the rest.
2. Scan and upload the form.
3. Alternatively bring the forms to FPD and Coach Law will upload them for you.