ISLE OF WIGHT ACADEMY

Home of the Chargers

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 a copy of this form in the chart.)

Name _____ Date of Birth _____

Date of Exam _____ Sex Age Grade

School Sport(s)

MEDICINES AND ALLERGIES:

Please list all of the prescriptions 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 : ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Please list what the student is allergic to: _____

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Have 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?		

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 ever been unable to move your arms or legs after being hit or falling?		
34. Have you ever become ill while exercising in the heat?		
35. Do you get frequent muscle cramps when exercising?		
36. Do you or someone in your family have sickle cell trait or disease?		
37. Have you had any problem with your eyes or vision?		
38. Have you had any eye injuries?		
MEDICAL QUESTIONS (cont.)	**YES**	**NO**

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 the age of 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, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defribulator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Y**	**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 ever 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 a history of juvenile arthritis or connective tissue disease?		

39. Do you wear contact lenses?		
40. Do you wear protective eyewear such as goggles or face shield?		
41. Do you worry about your weight?		
42. Are you trying to or has anyone recommended that you gain or lose weight?		
43. Are you on a special diet or do you avoid certain types of foods?		
44. Have you ever had an eating disorder?		
45. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**YES**	**NO**
46. Have you ever had a menstrual period?		
47. How many periods have you had in the past 12 months?		

Explain the "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/Date

_____ Signature of Parent/Guardian /Date

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Physical Evaluation: Physical Examination Form

(Note: This form is to be filled out by the attending physician.)

Name _____ Date of Birth_____ _____

Date of Exam _____ Sex _____ Age _____ Grade _____

EXAMINATION		
Height Weight ¨ Male ¨ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance: Marfan sigmata (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 (ausculation standing, supine, +/- Valsalva *Location point of maximal impulse (PM)		
Pulses: Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin: HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		

Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[Consider] ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [Consider] GU exam in private setting. Having third party present is recommended. [Consider] cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clearance Acknowledgment

Name: _____ DOB _____

☐ 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 examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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

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Acknowledgement of Risk and Insurance Statement

I authorize the participation of _____ in all of the following sports that are NOT crossed out: baseball, basketball, cheerleading, cross country, football, golf, soccer, softball, volleyball, weight lifting, track and _____ (other).

I am generally familiar with the eligibility rules for each such sport and to the best of my knowledge my child has no health problems that adversely affect the ability of my child to participate in any such sports. In the event my child develops any such health problems, I will immediately notify the school's Athletic Director.

I understand that the coaches of each sport may establish rules and regulations relative to attendance at practices, training, study schedules, and other matters for the purpose of promoting the well being of the team, as well as the punishment for the non-compliance with such rules and regulations.

I agree that I will be supportive of such rules and regulations and their enforcement.

I am familiar with the requirements for participation in each sport for which I have authorized my child's participation and I recognize and understand that any physical activity can present an increased risk of injury and possibly death and that participation in sports exposes participants to such risks.

I understand through my own personal experiences and observations, literature I have read, or otherwise, that my child's exposure to such risks and the degree of danger and seriousness of such risks varies significantly from one sport to another and that sports involving personal contact of the participants carries higher risks.

I understand that my child's participation in sports may involve travel with the teams and I grant permission for my child to travel to and from such sporting events with transportation provided by the school.

I understand that in the event that such transportation is not in a school-owned vehicle, that it will be necessary in each event for me to specifically authorize my child's traveling in a privately owned vehicle and in such event the school will have no liability for any claim that may arise out of an event incident to such transportation.

I accept that there are some risks involved in athletics and I am aware that injury may occur during participation. I do not hold the Isle of Wight Educational Foundation responsible for injuries received during participation.

Acknowledging the risks involved with sports participation and team travel, and in the absence of negligence of Isle of Wight Academy, it's employees and agents contributing to any such injury and/or possible death, I agree to indemnify and save harmless Isle of Wight Academy, its employees and agents from and against any and all liability for any such events as well as any and all costs and fees incurred by Isle of Wight Academy in the defense of any such claims.
This document will remain in effect for one year unless written notification is received to the contrary.

_____ _____

SIGNATURE OF PARENT/GUARDIAN: Date *SIGNATURE OF PARENT/GUARDIAN: Date

*(Both parents/guardians must sign the above Acknowledgement of Risk and Insurance Statement. Students may not participate in athletics at Isle Of Wight Academy without the proper signatures of parents or guardians.)

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MEDICAL INSURANCE INFORMATION

(__) Insured by our family policy with _____

Policy # _____

EMERGENCY PERMISSION FORM

Student's Name: _____Grade :_____

Date of Birth: _____ Age : _____ Sex: M F

Please list any health problems that might be significant to a physician evaluating your child in case of an emergency:

Is student allergic to any medications? Yes/No (If yes, please state which ones)

Is student currently taking any medications? Yes/No (If yes, please state which ones):

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EMERGENCY AUTHORIZATION/PERMISSION TO TREAT

In the event I cannot be reached, I hereby give permission to physicians selected by the coaches or staff at Isle of Wight Academy to hospitalize, secure proper treatment for, and to order injection and/or surgery for the person named above who is a student currently enrolled at Isle of Wight Academy.

*SIGNATURE OF PARENT/GUARDIAN Date

_____ _____

Phone Number:

_____ (Home) _____ (Work)

_____ (Cell)

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*SIGNATURE OF PARENT/GUARDIAN Date

_____ _____

Phone Number:

_____ (Home) _____ (Work)

_____ (Cell)

***Both parents/guardians must sign the above Emergency Authorization/Permission to Treat prior to the student's participation in any sporting activity.** This form may be reproduced for travel with respective teams and is acceptable for emergency treatment if needed.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE ATHLETIC DIRECTOR of ISLE OF WIGHT ACADEMY BEFORE STUDENT IS PERMITTED TO TRY OUT FOR OR PARTICIPATE IN ANY ATHLETIC ACTIVITIES.