

Schuylkill Valley School District
PIAA PREPARTICIPATION PHYSICAL EVALUATION FORM

First Sport of the Year

Student Information (to be completed by parent)

Student's Name: _____ Gender: _____ Age: _____ DOB: ____/____/____

Sport: _____ Grade During the Sport Season: _____

Address: _____ City: _____ Zip: _____

Student Ethnicity: (circle one) American Indian/Alaskan Native Black Hispanic White Multi-Racial Asian Native Hawaiian/Pacific Islander (info for PA reporting only)

Parent E-mail: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____

Emergency Contact: _____ Relationship to Student: _____

Home phone: (____) _____ Work Phone: (____) _____ Cellular phone: (____) _____

Primary Care Physician: _____ City: _____ Office Phone: (____) _____

Medical Insurance Carrier: _____ Policy Number _____

Student's Allergies: _____

Student's Health Condition (s) of which an Emergency Physician Should be Aware: _____

Student's Prescription Medications: _____

Student's Immunizations (e.g. tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza, Poliomyelitis, Pneumococcal; meningococcal; varicella)

_____ Up to Date

_____ Not Up to Date Specify _____

PLEASE EXPLAIN ALL YES ANSWERS AT THE BOTTOM OF THIS SECTION (circle **Y** for YES and **N** for NO):

1. Y N Has a doctor ever denied or restricted your participation in sport(s) for any reason?
2. Y N Do you have an ongoing medical condition (like Asthma or diabetes)?
3. Y N Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
4. Y N Do you have allergies to medicines, pollens, foods, or stinging insects?
5. Y N Have you ever passed out or nearly passed out DURING exercise?
6. Y N Have you ever passed out or nearly passed out AFTER exercise?
7. Y N Have you ever had discomfort, pain or pressure in your chest during exercise?
8. Y N Does your heart race or skip beats during exercise?
9. Y N Has your doctor ever told you that you have (check all that apply):
 _____ High Blood Pressure _____ High Cholesterol _____ Heart Murmur _____ Heart Infection
10. Y N Has a doctor ever ordered a test for your heart (EX – ECG, echocardiogram)
11. Y N Has anyone in your family died for no apparent reason?
12. Y N Does anyone in your family have a heart problem?
13. Y N Has any family member or relative died of heart problem or of sudden death before age 50?
14. Y N Does anyone in your family have Marfan syndrome?
15. Y N Have you ever spent a night as a patient in the hospital?
16. Y N Have you ever had a stress fracture?
17. Y N Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below

18. Y N Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or contest?
If yes, circle affected area below
19. Y N Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below.
20. Y N Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections rehabilitation, physical therapy, a brace a cast or crutches? If yes, circle affected area below

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand	Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot	Toes

CONTINUED ON NEXT PAGE

PIAA Preparticipation Physical Evaluation Form – page 2

21. Y N Have you ever been told that you have, or have you had an x-ray for, atlantoaxial (neck) instability?
22. Y N Do you regularly use a brace or assistive device?
23. Y N Has a doctor ever told you that you have asthma or allergies?
24. Y N Do you cough, wheeze or have difficulty breathing DURING or AFTER exercise?
25. Y N Is there anyone in your family who has asthma?
26. Y N Have you ever used an inhaler or taken asthma medicine?
27. Y N Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
28. Y N Have you had infectious mononucleosis (mono) within the last month?
29. Y N Do you have any rashes, pressure sores, or other skin problems?
30. Y N Have you had a herpes skin infection?
31. Y N Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?
32. Y N Have you ever been hit in the head and been confused or lost your memory?
33. Y N Do you experience dizziness and/or headaches with exercise?
34. Y N Have you ever had a seizure?
35. Y N Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
36. Y N Have you ever been unable to move your arms or legs after being hit or falling?
37. Y N When exercising in the heat, do you have severe muscle cramps or become ill?
38. Y N Has your doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
39. Y N Have you had any problems with your eyes or vision?
40. Y N Do you wear glasses or contact lenses?
41. Y N Do you wear protective eyewear, such as goggles or a face shield?
42. Y N Are you unhappy with your weight?
43. Y N Are you trying to gain or lose weight?
44. Y N Has anyone recommended you change your weight or eating habits?
45. Y N Do you limit or carefully control what you eat?
46. Y N Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

47. Y N Have you ever had a menstrual period?
48. If yes, how old were you when you had your first menstrual period? _____
49. How many periods have you had in the past twelve (12) months? _____
50. Y N Are you pregnant?

Please explain any yes answer to questions 1 – 50 in the space below

No(s).	Please explain "YES" answers here:

I hereby certify that to the best of my knowledge all information contained herein is true and complete.

Parent/Guardian Signature _____ Date _____

I hereby certify that to the best of my knowledge all information contained herein is true and complete.

Student Signature _____ Date _____

CONTINUED ON NEXT PAGE

PIAA Preparticipation Physical Evaluation Form – page 3

Understanding of Eligibility Rules and Schuylkill Valley Athletic Code – I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School practices or Scrimmages and Contests involving PIAA member schools. Such requirements, which are posted on the PIAA web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation and academic performance. I further acknowledge that both the student contained herein and the parent/guardian have read and are familiar with the Schuylkill Valley Athletic/Activity Code.

Disclosure of Records Needed to Determine Eligibility – To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools and to determine academic awards, I hereby consent to the release to PIAA and school district personnel of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received and attendance data.

Permission to Use Name, Likeness, and Athletic Information – I consent to PIAA and SVSD's use of the herein named student's name, likeness, and athletically related information in reports of Inter-School Practices or Scrimmages and Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Permission to Administer Emergency Medical Care – I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices or Scrimmages and Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care.

I hereby certify that to the best of my knowledge that the aforementioned information is true and complete.

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion? A concussion is a brain injury that is caused by a bump, blow or jolt to the head or body. It can change the way a student's brain normally works. It can occur during practices or contests in any sport and can happen even if a student has not lost consciousness. It is serious even if a student has been "dinged" or "had their bell rung." All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal. Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion? Concussions cannot be seen; however, in a potentially concussed student, **one or more** of the following symptoms listed may become apparent and/or the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- | | | |
|----------------------------------|--|-------------------------------|
| - Headache or "pressure" in head | - Nausea or vomiting | - Confusion |
| - Balance problems or dizziness | - Double or blurry vision | - Memory problems |
| - Bothered by light or noise | - Feeling sluggish, hazy, foggy, or groggy | - Difficulty paying attention |

What should students do if they believe that they or someone else may have a concussion? Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents. Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach. The student will then be referred to the Schuylkill Valley Athletic Trainer and School Physician. These individuals will then follow the SV Concussion protocol in treating the student.

Concussed students should give themselves time to get better. If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from the Athletic Trainer and Team Physician and is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves. Students should use proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be the right equipment for the sport, position, or activity and it must be worn correctly and the correct size and fit. It must be used every time the student practices and/or competes. The student must also follow the coach's rules for safety and the rules of the sport and practice good sportsmanship at all time.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

UNDERSTANDING SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest? Sudden Cardiac Arrest (SCA) is when the heart stops beating suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is not a heart attack, which may cause SCA; however, they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is SCA in the United States and what are the warning signs? There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 35 die of SCA each year. Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- | | | |
|------------------------|-----------------------|---|
| - Dizziness | - Fatigue | - Lightheadedness |
| - Weakness | - Shortness of breath | - Nausea |
| - Difficulty breathing | - Vomiting | - Racing or fluttering heartbeat (palpitations) |
| - Chest pains | - Syncope (fainting) | |

What are the risks of practicing or playing after experiencing these symptoms? There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it. Any student-athlete who has signs or symptoms of SCA must be removed from play (including all athletic activity). The symptoms can happen before, during or after activity. Before returning to play, the athlete must be evaluated and clearance to return must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner or cardiologist. These individuals may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

PIAA EVALUATION and CERTIFICATION of AUTHORIZED MEDICAL EXAMINER

Form must be completed and signed by the Authorized Medical Examiner performing the herein named student's comprehensive initial preparticipation physical evaluation and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name: _____ Age: _____ Grade: _____

Sport(s): _____ Enrolled in: Schuylkill Valley School District

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____/_____
Age 10-13 BP>126/82 RP>104 Age 13-15 BP>136/86 RP>100 Age 16-25 BP142/92 RP>96

Vision R20/____ L20/____ Corrected YES NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL NORMAL ABNORMAL FINDINGS

Appearance _____

Eyes/Ears/Nose/Throat _____

Hearing _____

Lymph Nodes _____

Cardiovascular _____ ☐ Heart Murmur ☐ Femoral Pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan Syndrome

Cardiopulmonary _____

Lungs _____

Abdomen _____

Genitourinary (males only) _____

Neurological _____

Skin _____

MUSCULOSKELETAL

Neck _____

Back _____

Shoulders/Arms _____

Elbows/Forearms _____

Wrists/Hands/Fingers _____

Hips/Thighs _____

Knees _____

Legs/Ankles _____

Feet/Toes _____

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial preparticipation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian on the PIAA Preparticipation Physical Evaluation Form and further certify that the student does not have any communicable illness or condition which would pose a danger to teammates and/or competitors:

_____ CLEARED _____ CLEARED, with recommendation(s) for further evaluation or treatment for: _____

_____ NOT CLEARED for the following type of sports (please check all the apply)

_____ Collision _____ Contact _____ Non-Contact _____ Strenuous _____ Moderately Strenuous _____ Non-Strenuous

Due to _____

Recommendation(s)/Referral(s) _____

Authorized Medical Examiner's Name (print/type if different from above): _____ License # _____

Address: _____ Phone _____

Medical Examiner's Signature _____ MD/DO/PAC/CRNP/SNP(circle one) Date _____

**** MUST BE AUTHORIZED AFTER JUNE 1 FOR EACH NEW SCHOOL YEAR ****