CHSAA

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 7)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

1

Revised 6/25

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___ /___ /____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

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

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
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

Mental Health Immediate Resources: Colorado Crisis https://coloradocrisisservices.org/ Call/text 988 or live chat at 988Colorado.com.
For additional Mental Health Resources, Please go to https://chsaanow.com/sports/2021/7/22/smac.aspx

	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 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?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
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? (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), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 7)

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Revised 6/25

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	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?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports- related injuries and death. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/ their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/ they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___/___/_____ School: _____

PHYSICIAN REMINDERS:

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?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION		
Height:	**Weight:**	
BP: / (/) **Pulse:**	**Vision:** R 20/ L 20/	**Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	**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 • 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 - healthcare professional shall initial each assessment	**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		

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (____) _____ E-mail: _____

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PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 7)

SUBMIT ONLY THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

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Revised 6/25

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

List any medical history that is relevant to participation in competitive sports. ***(explain below, use additional sheet, if necessary)***

_____

_____

_____

☐ Allergies/Anaphylaxis ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait
☐ Mental Health ☐ N/A – No relevant medical information to disclose

Medications: *(use additional sheet, if necessary)*

List: _____

_____

****Signature of Student:** _____ **Date:** _____/_____/_____

****Signature of Parent/Guardian:** _____ **Date:** _____/_____/_____

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete & signed.

This entire packet must be submitted to the VCHS Sports Medicine Department

This form is valid for 365 days from the date of the healthcare provider's signature

Student's Full Legal Name: _____ Date of Birth: ____/____/____ School of Athletics: _____

Appointment of Health Care Representative

As the parent/guardian of the student listed below, I request that in my absence the above named child/ student-athlete be treated by the VCHS Sports Medicine Department staff for sports related injuries and emergency medical conditions. I request treatment and admittance to any hospital or medical facility for diagnosis and treatment of life threatening illness/injury sustained during athletic participation. I request and authorize affiliate physicians and other medical specialist to perform any diagnostic, treatment, and/or operative health care procedures that are medically necessary to the above named individual during a life threatening illness/injury sustained during athletic participation.

I hearty accept financial responsibility for any and all medically necessary treatment administered to the above named child/student-athlete in the event of an accident/injury sustained during athletic participation to the same extent as if I had personally contracted for such care and services and agree to pay all such charges.

These powers shall be effective at the start of each academic year and shall terminate on the last day of the academic year; unless the child/student-athlete participates in a School organized summer athletic activity, whereby these powers shall remain effective until the start of the following academic year.

General Release

I understand the above named child/student-athlete assumes all of the risks associated with the activities in which he or she will be involved. I release all rights and claims for damages which the above named child/student-athlete or I may have against the School, its directors, coaches, officials, teachers, or representatives for injuries or damages that occur as a result of their participation.

HIPAA Authorization

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as the parent/legal guardian of the student listed below, I am his/her Personal Representative. As such, I appoint and designate VCHS Sports Medicine Department staff as his/her Personal Representative, to serve concurrently and individually. I authorize the Health Care Representative(s) to use and disclose the protected health information to the School, its Concussion Response Team (CRT) members, necessary director(s)/administrator(s), necessary coaches, teachers, or representatives pertaining to the above child/student-athlete related to illness/injury sustained during athletic participation.

These powers shall be effective at the start of each academic year and shall terminate on the last day of the academic year; unless the child/student-athlete participates in a School organized summer athletic activity, whereby these powers shall remain effective until the start of the following academic year.

I have read this form and I fully agree to the terms presented above.

Student-Athlete (Printed)	Student-Athlete (Signature)	Date
Parent/Guardian (Printed)	Parent/Guardian (Signature)	Date

This form is valid for 365 days from the date of the healthcare provider's signature

Student's Full Legal Name: _____ Date of Birth: ____/____/____ School of Athletics: _____

1. Learn the early warning signs:

If 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 member who has 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

2. Learn to recognize Sudden Cardiac Arrest

If you see someone collapse, assume he/she has 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). Send for help and start CPR immediately as this action will not hurt the victim.

3. Learn hands-only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until emergency rescue services arrive. It is one of the most important life skills you can learn.

- Call 911 (or ask bystanders to call 911 then retrieve an AED)
- Knee at the victim's side, place your hands on the lower half of the breastbone, one hand on top of the other, elbows straight and locked. Push hard and fast in the center of the chest. Push down 2 inches, then up 2 inches, at a rate of 100 times per minute, to the beat of the song "Stayin' Alive".
- If an Automated External Defibrillator (AED) is available, open it and following 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 to restart the heart.

By signing this Sudden Cardiac Arrest form, I am stating awareness of the dangers of Sudden Cardiac Arrest and this signed Sudden Cardiac Arrest form will represent myself and my child during the academic school year.

I have read this form and I understand the facts presented about Sudden Cardiac Arrest.

Student-Athlete (Printed)	Student-Athlete (Signature)	Date
Parent/Guardian (Printed)	Parent/Guardian (Signature)	Date

CONCUSSION AWARENESS FORM (Page 7 of 7)

This entire packet must be submitted to the VCHS Sports Medicine Department

This form is valid for 365 days from the date of the healthcare provider's signature

Student's Full Legal Name: _____ Date of Birth: ___/___/____ School of Athletics: _____

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 a 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. 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 or activity following a concussion can lead to worsening concussion symptoms, as well as, increased risk of further injury to the brain and even death. Student-athlete and parental education in this area is crucial.

Common Signs and Symptoms of a Concussion

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

In accordance with Colorado law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall immediately be removed from the practice or contest and shall not return to play until an appropriate health care professional (a licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer) has determined that no concussion has occurred.

- No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) can not be ruled out.
- Any athlete diagnosed with a concussion shall be cleared medically by an appropriate healthcare professional prior to resuming participation in any further practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I am stating awareness of the dangers of concussions in sports and this signed concussion awareness form will represent myself and my child during the academic school year.

I have read this form and I understand the facts presented about concussions in sports.

Student-Athlete (Printed)	Student-Athlete (Signature)	Date
Parent/Guardian (Printed)	Parent/Guardian (Signature)	Date