

COMMUNITY HEALTH CENTER OF LUBBOCK

providing

SPORTS PHYSICALS



for

ROOSEVELT EAGLES

MAY 24, 2018

**Don't forget your
glasses/contacts**

ONLY \$15

**Don't forget your
glasses/contacts**



**CASH AND
CHECKS ONLY**



PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____					
How severe was each one? (Explain below)			<i>Females Only</i>		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Males Only</i>		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have two testicles? _____		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you have any testicular swelling or masses? _____		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):**

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. * **Local district policy may require an annual physical exam.**

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.



EHS # _____

Payment:

- CASH
- CHECK # _____

For office use only

Sports Physical Consent Form

(To be completed by guardian)

Blue or Black Ink ONLY

Student Name: _____ DOB: _____

School Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

Sex: [] Male [] Female Race/Ethnicity: [] White [] Black [] Hispanic [] Asian [] Other

Guardian Name: _____ Relationship: _____

Guardian Phone Number: _____ Guardian DOB: _____

Address (if different from above): _____

How are you paying?

[] Cash [] Check (pay to the order of CHCL)

- You agree that your child is voluntarily participating in this Sports Physical exam and will have this exam while you are not present;
- You understand that this is a sports physical only and is not a complete examination (Texas Health Step) and should not be substituted for a full examination by your primary care provider;
- You understand that if you have a primary care provider the responsibility for any follow-up examinations to check for abnormalities found during this screening lies with you, and not with any participating organization, physician or health care volunteer;
- If your child *DOES NOT* have a primary care provider Community Health Center of Lubbock, Inc. staff can schedule a follow up examination to check any abnormalities found during the sports physical screening with a Community Health Center of Lubbock, Inc. provider;
- Would you like to have an appointment made at one of the Community Health Center of Lubbock, Inc. sites, if your child needs a follow up examination?
 Yes No
- You understand that you are responsible for your child's own health;
- You agree to release Community Health Center of Lubbock, Inc., examining physicians, staff and any other participating organization(s) from liabilities, medical claims or expenses which may arise from participation in this screening or any injury sustained during this screening;
- The cost of the sports physical will be honored on the date your sports physical is done by Community Health Center of Lubbock, Inc. staff. If an appointment is set for a Community Health Center of Lubbock, Inc. site the cost of the appointment will be based by clinic rate.

By your signature below, you acknowledge that you have read this form and understand its contents.

Signature: _____ Date _____