PRE-PARTICIPATION PHYSICAL EVALUATION FOR ATHLETICS

To Parents or Guardians:

Students enrolled in grades 9-12 must have an annual pre-participation physical evaluation, dated April 1, 2020 or later for this school year, in order to participate in Frederick County Public Schools (FCPS) interscholastic and corollary athletics.

The medical evaluation shall be performed by a licensed physician, a certified nurse practitioner, or a certified physician assistant under the supervision of a licensed physician.

The pre-participation physical evaluation consists of three parts: History Form (page 1), Physical Examination Form (page 2), and Supplemental History Form for Athletes with Special Needs (page 3).

When a student-athlete has experienced a significant injury, illness, or surgery after submitting the annual pre-participation physical evaluation, a clearance letter from a physician, nurse practitioner, or certified physician assistant under the supervision of a licensed physician is required to resume participation.

The health information submitted to the school will be available only to those health and education personnel who have a legitimate educational interest in your child.

Sports starting dates for 2020-2021 are:

- Fall – Wednesday, August 12, 2020
- Winter – Saturday, November 14, 2020
- Spring – Monday, March 1, 2021

www.fcps.org/athletics
Twitter: @FCPSAthletics
Preparticipation Physical Evaluation

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam

Name

Date of birth

Sex  Age  Grade  School  Sport(s)

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking below:

--

Do you have any allergies?  Yes  No  If yes, please identify specific allergy below:

□ Medicines  □ Pollens  □ Food  □ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No

2. Do 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?  Yes  No

4. Have you ever had surgery?  Yes  No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?  Yes  No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  Yes  No

7. Does your heart ever race or skip beats (irregular beats) during exercise?  Yes  No

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)  Yes  No

10. Do you get lightheaded or feel more short of breath than expected during exercise?  Yes  No

11. Have you ever had an unexplained seizure?  Yes  No

12. Do you get more tired or short of breath more quickly than your friends during exercise?  Yes  No

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  Yes  No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  Yes  No

15. Has anyone in your family had a heart problem, pacemaker, or implanted defibrillator?  Yes  No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  Yes  No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  Yes  No

18. Have you ever had any broken or fractured bones or dislocated joints?  Yes  No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  Yes  No

20. Have you ever had a stress fracture?  Yes  No

21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)  Yes  No

22. Do you regularly use a brace, orthotics, or other assistive device?  Yes  No

23. Do you have a bone, muscle, or joint injury that bothers you?  Yes  No

24. Do any of your joints become painful, swollen, feel warm, or look red?  Yes  No

25. Do you have any history of juvenile arthritis or connective tissue disease?  Yes  No

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes  No

27. Have you ever used an inhaler or taken asthma medicine?  Yes  No

28. Is there anyone in your family who has asthma?  Yes  No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  Yes  No

30. Do you have groin pain or a painful bulge or hernia in the groin area?  Yes  No

31. Have you had infectious mononucleosis (mono) within the last month?  Yes  No

32. Do you have any rashes, pressure sores, or other skin problems?  Yes  No

33. Have you had a herpes or MRSA skin infection?  Yes  No

34. Have you ever had a head injury or concussion?  Yes  No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  Yes  No

36. Do you have a history of seizure disorder?  Yes  No

37. Do you have headaches with exercise?  Yes  No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes  No

39. Have you ever been unable to move your arms or legs after being hit or falling?  Yes  No

40. Have you ever become ill while exercising in the heat?  Yes  No

41. Do you get frequent muscle cramps when exercising?  Yes  No

42. Do you or someone in your family have sickle cell trait or disease?  Yes  No

43. Have you had any problems with your eyes or vision?  Yes  No

44. Have you had any eye injuries?  Yes  No

45. Do you wear glasses or contact lenses?  Yes  No

46. Do you wear protective eyewear, such as goggles or a face shield?  Yes  No

47. Do you worry about your weight?  Yes  No

48. Are you trying to or has anyone recommended that you gain or lose weight?  Yes  No

49. Are you on a special diet or do you avoid certain types of foods?  Yes  No

50. Have you ever had an eating disorder?  Yes  No

51. Do you have any concerns that you would like to discuss with a doctor?  Yes  No

FEMALES ONLY

52. Have you ever had a menstrual period?  Yes  No

53. How old were you when you had your first menstrual period?  Yes  No

54. How many periods have you had in the last 12 months?  Yes  No

Explain “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  Signature of parent/guardian  Date

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# PHYSICAL EXAMINATION FORM

**Name** ___________________________  **Date of birth** ___________________________

## EXAMINATION

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## MEDICAL

### MEDICAL FINDINGS

- **Appearance**
  - Marfan stigmata (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**
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- **Pulses**
  - Simultaneous femoral and radial pulses

- **Lungs**

- **Abdomen**

- **Genitourinary (males only)**

- **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

## Allergies

- ___________________________________________________________________________

## Pertinent Information for Coaches/Trainers/Athletic Directors (I.E. concussion, diabetes, seizure disorder, cardiac issues, asthma, etc.)

- ___________________________________________________________________________

- ___________________________________________________________________________

- ___________________________________________________________________________

- ___________________________________________________________________________

## Signature of LHCP

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Signature of LHCP ___________________________  Date ___________________________

Address __________________________________________________  Phone ___________________________

Name of physician (print/type) ___________________________  Date ___________________________

Address __________________________________________________  Phone ___________________________

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# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam __________________________ Date of birth __________________

Name __________________________ Sex ________ Age ________ Grade ________ School __________________________ Sport(s) ________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

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6. Do you regularly use a brace, assistive device, or prosthesis?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

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Please indicate if you have ever had any of the following.

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Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteopenia or osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

Explain “yes” answers here

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

Signature of athlete __________________________ Signature of parent/guardian __________________________ Date ________________
PRE-PARTICIPATION COVID-19
Supplemental Questions for Student’s Physical

This form should be completed by the student’s physician at the time of a physical.

Student History

1. Has your child or adolescent been diagnosed with COVID-19?
   Yes   No

2. Was your child or adolescent hospitalized as a result for complications of COVID-19?
   Yes   No

3. Has your Child been diagnosed with Multi-inflammatory Syndrome in Children?
   Yes   No

4. Has your child or adolescent had direct known exposure to someone diagnosed with COVID-19?
   Yes   No

Please address any "yes" answers to the above questions here:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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