GEORGIA HIGH SCHOOL ASSOCIATION

GHSA PreParticipation Evaluation Form Instructions

These forms may be completed digitally or print/complete

1. Complete and print the 8 page form below prior to the appointment with your child's physician
2. Bring the completed forms with you to your child's appointment
3. Request a copy of these forms from your physician's office
   - *The physician's office will not send a copy of your child's forms to Mount Vernon School due to HIPPA*
4. **Upload and submit a scanned PDF of these forms via Lookup Athletic's "Required Form" webpage**
   - *Photo submission of forms will not be accepted*
   - *Immunization records should only be submitted to your child's grade level School nurse*
5. Retain a copy of these forms for your own personal records

Please note, a PreParticipation Evaluation Physical or "sports physical" is considered a non-essential examination by most all insurance companies and is a separate examination from a "wellness exam"; thus, your physician's office may charge a separate fee.

MOUNT VERNON SPORTS MEDICINE

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PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Date of Examination: Physician Use

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Current/Rising Grade Level: _____ Sport(s): _____

Sex assigned at birth (F, M, or other): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

	Not at all	Several days	Over half the days	Nearly every day
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

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

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 illness?		
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?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
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 years (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), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. 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?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Have you used an inhaler for asthma in the past year? **YES** ☐ **NO** ☐

Do you carry an asthma inhaler? **YES** ☐ **NO** ☐

Have you used an EpiPen in the past year? **YES** ☐ **NO** ☐

Do you carry an EpiPen? **YES** ☐ **NO** ☐

Explain all "YES" answers here: _____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete: _____

Signature of parent/guardian: _____

Signature Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. 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?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Physician Use Weight: Physician Use		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**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[a] • 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	**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		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

ALL PAGES OF THIS DOCUMENT MUST BE COMPLETED AND RETURNED TO THE SCHOOL'S SPORTS MEDICINE DEPARTMENT

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ **Medically eligible for all sports without restriction**

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Medication Allergies: _____

Environmental Allergies: _____

Food Allergies: _____

Current Rx Medications: _____

Treatment For: _____

Current Over-the-Counter Medications: _____

Treatment For: _____

Current Vitamins/Supplements: _____

Emergency Contact (Mother) - Phone: _____ Email: _____

Emergency Contact (Father) - Phone: _____ Email: _____

Emergency Contact (Other) - Phone: _____ Email: _____

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ANNUAL ATHLETIC PARTICIPATION MEDICAL CONSENT AND RELEASE

PLEASE SUBMIT ALL PAGES OF THIS DOCUMENT

Appointment of Health Care Representative

As the parent/legal guardian of _____, I request that in my absence the above named child/student-athlete be treated by the Mount Vernon Sports Medicine Department staff, to include the designated Children's Healthcare of Atlanta (CHOA) athletic trainer for sports related injuries. 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, nurses, dentists 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 hereby 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 (i.e. CHOA athletic trainer) 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 _____, I am his/her Personal Representative. As such, I appoint and designate Mount Vernon 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 (i.e. CHOA affiliates) 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.

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SUDDEN CARDIAC ARREST AWARENESS

The State of Georgia Legislature has passed a requirement to inform coaches, parents, and student-athletes about the risk of Sudden Cardiac Arrest (SCA).

What is Sudden Cardiac Arrest (SCA)?
Sudden Cardia Arrest (SCA) is the sudden onset of an abnormal and lethal heart rhythm, causing the heart to stop beating and the individual to collapse. SCA is the leading cause of death in the U.S., afflicting over 300,000 individuals per year. SCA is also the leading cause of sudden death in young athletes during sports.

What Causes Sudden Cardiac Arrest (SCA)?
SCA in young athletes is usually caused by a structural or electrical disorder of the heart. Many of these conditions are inherited (genetic) and can develop as an adolescent or young adult. SCA is more likely to occur during exercise or physical activity, placing student-athletes with undiagnosed heart conditions at a greater risk. SCA also can occur from a direct blow to the chest by a firm projectile or by chest contact from another player (called "commotio cordis").

Learn the Early Warning Signs
If you or 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 members who have 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

Learn to Recognize Sudden Cardiac Arrest
If you see someone collapse, assume that person 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 begin CPR.

Learn Hands-Only CPR
Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue responders arrive. It is one of the most important life skills you can learn - and it is easier than ever.

1. Call 911 (or ask a bystander to call 911), then, obtain an AED if available
2. Begin CPR. Kneel at the victim's side and place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then release compression allowing the chest to rise 2 inches, at a rate of 100 times per minute.
3. If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. The AED will lead you step-by-step through the process, and will determine if a shock is required to re-start the heart.

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CONCUSSION AWARENESS

What is a concussion? A concussion is a brain injury that results in a temporary disruption of normal 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.

Dangers of a Concussion

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 (either short-term or long-term). Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as, increased risk for further injury to the brain, and even death.

Common Signs and Symptoms of a Concussion

- **Difficulty thinking clearly**
- **Taking longer to figure things out**
- **Difficulty concentrating**
- **Difficulty remembering new information**
- **Headache**
- **Fuzzy or blurry vision**
- **Feeling sick to your stomach**
- **Vomiting**
- **Dizziness**
- **Balance problems**
- **Sensitivity to noise or light**
- **Irritability - things bother your more easily**
- **Sadness**
- **Being more moody**
- **Feeling nervous or worried**
- **Crying more**
- **Sleeping more/less than usual**
- **Trouble falling asleep**
- **Feeling tired**

By-Law 2.68: GHSA Concussion Policy

In accordance with Georgia 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 be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred.

NOTE: An appropriate health care professional may include, 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 who has received training in concussion evaluation and management.

a) 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) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

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ImPACT TESTING CONSENT

ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If a student-athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to student-athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 45 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the student-athlete will be required to re-take the test conducted by either the Mount Vernon Sports Medicine Department staff or representatives (i.e. CHOA affiliates). Both the preseason and post-injury test data may be used to help evaluate the depth of a concussion. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured student-athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details. ImPACT testing procedures are non-invasive, and they pose no risks to your child.

Note, ImPACT baseline testing is administered annually for free to "High-Risk" Upper School student-athletes only.

CONSENT OF UNDERSTANDING AND ACKNOWLEDGEMENT

I, _____, parent/legal guardian of _____, have read and understand the above information required by the School, Georgia High School Association, and Children's Healthcare of Atlanta. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree and consent to all information presented above as legal representative of named child/student-athlete.

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

Printed Name of Parent/Guardian: _____

Date of Signature: _____

Signature of Child/Student-Athlete: _____

Printed Name of Child/Student-Athlete: _____

Date of Signature: _____

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