ALMA MIDDLE SCHOOL PHYSICAL PACKET CHECKLIST

This checklist is for 2019-20 school year 7th & 8th graders.

____ FILL OUT MEDICAL HISTORY FORM

____ HAVE PHYSICIAN PERFORM AND FILL OUT PHYSICAL FORM AND CLEARANCE FORM ****MAKE SURE SIGNED AND DATED BY PHYSICIAN****

____ READ AND SIGN CARDIAC FORM

____ READ AND FILL OUT AND SIGN CONSENT TO PLAY FORM

____ RETURN ALL FORMS BY JUNE 1ST TO THE ALMA MIDDLE SCHOOL OFFICE

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT:

PATTI ANN WEBB, M.S., AT
ATHLETIC TRAINER
ALMA HIGH SCHOOL
pwebb@almasd.net
479-670-3755

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

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

_____

_____

_____

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	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
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?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
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)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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 _____

HE0503 9-2681/0410

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, 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 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 (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL 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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

I hereby give my consent for _____ (student name) to compete in interscholastic sports, participate in related practice sessions and to travel with the team/coach for such functions. I acknowledge that even with proper instruction and supervision, proper use of equipment and strict observance of the rules, injuries and accidents are still a possibility. I understand that the Alma School District or its employees will not be liable if an injury or accident occurs. I also acknowledge and I understand the inherent risks of injuries, impairment, and/or death associated with participation in school athletic activity. I gave my consent for treatment at the best medical facility available in case of injury, accident or illness. I understand that I am required to have Primary Insurance coverage. The Alma School District has purchased Blanket Interscholastic Coverage for all participants. This policy provides secondary or supplemental coverage to students actively engaged in the play or practice of activities sponsored by the Arkansas Activities Association. Claims must be made within 30 days of the accident. I understand that the Alma School District will not be responsible for payment of any medical bill that the family's personal policy or the district's athletic insurance does not pay. I also agree to be responsible for the return of any athletic equipment issued to the above named student in quality condition.

Did the student/athlete attend Alma Public Schools for the entire previous school year?

___Yes ____No

Does the student currently reside in the Alma School District with the parent(s) that has/have legal primary custody of the student? ___ Yes ___No

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY.

_____

Signature of Parent/Guardian Date

_____

Signature of Student Athlete Date

Emergency Contact Information:

NAME: _____ CELL PHONE: _____

ADDRESS: _____ WORK PHONE: _____

NAME: _____ CELL PHONE: _____

ADDRESS: _____ WORK PHONE: _____

NAME: _____ CELL PHONE: _____

ADDRESS: _____ WORK PHONE: _____

Arkansas Activities Association
Sports Medicine Fact Sheet for Parents and Students

This document has been created by the Arkansas Activities Association Sports Medicine Advisory Committee. The committee's mission is to ensure Arkansas Activities Association member schools provide sound and consistent medical information to enhance the safety of their athletic programs. The AAA Sports Medicine Committee is committed to offering information and guidance to member schools on topics which impact the welfare of all those involved in interscholastic competition. The topics included in this fact sheet are: Exertional Heat Stroke, MRSA, Concussion, and Sudden Cardiac Arrest. The following pages contain important sports medicine information for parents and students. Please read the information and sign to acknowledge that you have received and reviewed the information.

Arkansas Activities Association
Exertional Heat Stroke Facts

WHAT IS EXERTIONAL HEAT STROKE

Heat stroke is a severe heat illness that occurs when a child's body creates more heat than it can release, due to the strain of exercising. This results in a rapid increase in core body temperature, which can lead to permanent disability or even death if left untreated.

WHAT ARE THE SIGNS AND SYMPTOMS OF HEAT STROKE

- Increase in core body temperature, usually above 104*F/40*C (rectal temperature)
- Central nervous system dysfunction, such as altered consciousness, seizures, confusion, emotional instability, irrational behavior or decreased mental acuity.
- Nausea, vomiting, diarrhea
- Headache, dizziness or weakness
- Hot and wet or dry skin
- Increased heart rate, decreased blood pressure or fast breathing
- Dehydration
- Combativeness

TREATMENT

- Locate medical personnel immediately. Remove extra clothing or equipment. Begin aggressively whole-body cooling by immersing in tub of cold water. If a tub is not available, use alternative cooling methods such as cold water fans, ice or cold towels (replaced frequently), placed over as much of the body as possible
- Call emergency medical services for transport to nearest emergency medical facility.

WHEN SHOULD I PLAY AGAIN?

No one who has suffered heat stroke should bee allowed to return until appropriate healthcare personnel approves and gives specific return to play instructions. Parents should work with medical professionals to rule out or treat any other conditions or illnesses that may cause continued problems with heat stroke. Return to physical activity should be done slowly, under the supervision of appropriate healthcare professionals.

Arkansas Activities Association
MRSA Facts

WHAT IS MRSA

MRSA is methicilliin-resistant Staphylococcus aureus, a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections. As with all regular staph infections, recognizing the signs and receiving treatment for MRSA skin infections in the early stages reduces the chances of the infection becoming severe. MRSA is spread by: having contact with another person's infections, sharing personal items such as towels or razors, that have touched infected skin, touching surfaces or items, such as used bandages, contaminated with MRSA.

WHAT ARE THE SIGNS AND SYMPTOMS MRSA

Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or other drainage
- Accompanied by fever.

WHAT IF I SUSPECT MRSA SKIN INFECTION

Cover the area with a bandage and contact your healthcare professional. It is especially important to contact your healthcare professional if signs and symptoms of an MRSA skin infections are accompanied by fever.

HOW ARE MRSA SKIN INFECTIONS TREATED

Treatment may include having a healthcare professional drain the infection and, in some cases, prescribe an antibiotic. Do not attempt to drain the infection yourself— doing so could worsen or spread it to others. If you are given an antibiotic, be sure to take all of the doses (even if the infection is getting better), unless your healthcare professional tells you to stop taking it.

HOW CAN I PROTECT MY FAMILY FROM MRSA SKIN INFECTIONS

- Know the signs and symptoms
- Get treated early
- Keep cuts and scrapes clean
- Encourage good hygene
- Clean hands regularly
- Discourage sharing personal items such as towels and razors.

FOR MORE INFORMATION, PLEASE CALL

1-800-CDC-INFO OR visit www.cdc.gov/MRSA

Arkansas Activities Association
Concussion Facts

WHAT IS A CONCUSSION

A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION

Observed by the Athlete

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory Problems
- Confusion
- Does not "feel right"

Observed by the Parent / Guardian, Coach, or Teammate

- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE PRESENT

Athlete

- TELL YOUR COACH IMMEDIATELY
- Inform parents
- Seek medical attention
- Give your self time to recover

Parent / Guardian

- Seek medical attention
- Keep your child out of play
- Discuss play to return to play with coach
- Address academic needs

WHERE CAN I FIND OUT MORE INFORMATION?

- Center for Disease Control
  www.cdc.gov/concussion/HeadUp/youth.html
- NFHS Free Concussion Course
  http://nfhslearn.com/electiveDetail.aspx?courseID=15000

RETURN TO PLAY GUIDELINES

1. Remove immediately from activity when signs/symptoms are present.
2. Release from medical professional required for return (Neuropsychologist, MD, DO, Nurse Practitioner, Certified Athletic Trainer, or Physician Assistant)
3. Follow school district's return to play guidelines and protocol

Arkansas Activities Association
Sudden Cardiac Facts

WHAT IS SUDDEN CARDIAC ARREST

Sudden cardiac arrest (SCA) is a condition in which the heart suddenly and unexpectedly stops beating. If this happens, blood stops flowing to the brain and other vital organs. The information presented below is to provide you with the knowledge you need to help the coach keep your child safe at practices and games.

WHAT ARE THE SIGNS AND SYMPTOMS OF SUDDEN CARDIAC ARREST

- Fainting or seizures during exercise
- Unexplained shortness of breath
- Chest pain
- Dizziness
- Racing heart beat
- Extreme fatigue

GUIDELINES FOR REMOVAL OF A STUDENT FROM ACTIVITY

- Every coach and registered volunteer must receive training every three years on prevention of sudden cardiac death.
- Every athlete and parent must read and sign the AAA Sports Medicine Fact Sheet containing information on sudden cardiac arrest.
- Any athlete experiencing syncope (fainting), chest pains, shortness of breath that is out of proportion to their level of activity or an irregular heart rate should not return to practice or play until evaluated by an appropriate healthcare professional (MD, DO, APN, Certified Athletic Trainer).
- The referred athlete must be medically cleared by an appropriate healthcare professional prior to return to play/practice.

SIGNATURES

By signing below, I acknowledge that I have received and reviewed the attached AAA Sports Medicine Fact Sheet for Athletes and Parents. I also acknowledge and I understand the risks of injuries associated with participation in school athletic activity.

_____	_____	_____
Athlete's Signature	Print Name	Date
_____	_____	_____
Parent / Guardian Signature	Print Name	Date