# PREPARTICIPATION PHYSICAL
# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. History Form is retained by physician/healthcare provider.

Name: _____ Date of birth: _____

Date of examination: _____ Grade: _____

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

List past and current medical conditions. _____

_____

Have you ever had surgery? It 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).

_____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response.)

| | 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 poly-morphic 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, tingling, 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 food and 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? | | |

**Explain "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 or guardian: _____

Date: _____

# PHYSICAL EXAMINATION

(Physical examination must be performed on or after April 1 by a health care professional holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) Rule 3-10

Name _____ Date of birth _____ Grade _____ IHSAA member School _____

## 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 last 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 use any other appearance/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 insuffiency | | |
| Eyes/ears/nose/throat | | |
| • Pupils equal | | |
| • Hearing | | |
| Lymphnodes | | |
| Heart | | |
| • Murmurs (auscultation standing, supine, +/- Valsalva) | | |
| • Location of point of maximal impuluse (PMI) | | |
| Pulses | | |
| • Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Skin | | |
| • MSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic | | |

**MUSCULOSKELETAL**

| | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |

| | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional | | |
| • Duck-walk, single leg hop | | |

☐ 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

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 Health Care Professional (print/type) _____ Date _____

Address _____ Phone _____ License # _____

Signature of Health Care Professional _____, MD, DO, PA, or NP (Circle one)

**- - - EMERGENCY MEDICAL AUTHORIZATION - - -**

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for players who become ill or injured while under coaches authority when parents or guardians cannot be reached. THIS FORM MUST BE FILLED OUT IN INK EACH SCHOOL YEAR!

Player's Name_____ Sport_____ Grade_____

Adddress_____
(Street) (City) (State) (Zip)
Phone_____Birthday_____

Father_____
(Name) (Employer) (Phone)
Mother_____
(Name) (Employer) (Phone)
Guardian_____
(Name) (Employer) (Phone)

Dependable relative or neighbor to call in an emergency (illness or injury)
When parent or guardian cannot be reached _____
(Name) (Phone)
Allergies _____ Date of last tetanus shot _____

Medication being taken _____
(Name) (Dosage) (Time(s) Taken)
List of health problems. For example: asthma, vision, epilepsy, diabetes, hearing, bone or muscle problems, etc. _____

Medical Insurance Firm_____ Policy #_____

**PART I OR II MUST BE COMPLETED**

**Part I – To Grant Consent:** If unable to reach parent or guardians, I hereby give my consent for 1) the administration of any treatment deemed necessary by _____ or
(Physician)
_____ in the event that the designated practitioner is not available another
(Dentist)
licensed physician or dentist and 2) the transfer of the player to _____
or any other hospital reasonably accessible. (Hospital)

This authorization does not cover surgery unless the medical opinions of two other licensed physicians or dentists concurring in the surgery are obtained prior to the performance of such surgery.

_____
(Date) (Signature of Parent of Guardian)

**Part II – Refusal to Consent:** I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish team authorities to take no action or to: _____

_____
(Date) (Signature of Parent or Guardian)

# Concussion and Head Injury & Sudden Cardiac Arrest Form

Student and Parent/Legal Guardian Acknowledgment Form

Student Athlete's Printed Name: _____ DOB: _____

School: _____ Student ID#: _____

Due to a new Indiana law "Student Athletes: Concussion and Head Injuries" and "Sudden Cardiac Arrest" (In. Codes 20-34-7, 20-34-8, *et seq.*), all schools are required to distribute information to student athletes and their parents/legal guardians about the nature and risks of sudden cardiac arrest, concussions and head injuries, including the risks of continuing to play after suffering a concussion or head injury. The law requires the following:

- Each year, before beginning practice for an interscholastic or intramural sport, a student athlete and the student athlete's parent/legal guardian must be provided an information sheet, and both must sign and return a form acknowledging the information.
- A student athlete who is suspected of suffering from sudden cardiac arrest, a concussion or head injury in a practice or game must be removed from play at the time of the injury and may not return to play until he/she has received a written clearance from a licensed health care provider trained in the evaluation and management of concussions and head injuries.

In addition to receiving written clearance, from the licensed health care provider referenced above, a high school student athlete who is suspected of suffering from sudden cardiac arrest or a concussion and is removed from play **must obtain clearance from the SBCSC's designated medical personnel before returning to play.**

## *What are the risks of continuing to play after a concussion or head injury?*

Continuing to play with the signs and symptoms of a concussion leaves an athlete vulnerable to greater injury. There is increased risk of significant damage from a concussion for a period of time after the concussion occurs, particularly if there athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences.

Please read the attached Fact Sheets, read the statement below, sign where indicated, and return this form to the school's athletic department.

I am a student athlete and I have received and read the ***Heads Up- Concussion in Sports - Fact Sheet for Athletes, and the Sudden Cardiac Arrest Form,*** as well as the information above. I understand the nature and risk of sudden cardiac arrest, concussions and head injuries to student athletes, including the risks of continuing to play after suffering a concussion or head injury, and the procedures that will be followed before returning to play.

| Student Athlete Printed Name | Student Athlete Signature | Date |
|---|---|---|

As the parent/legal guardian of the above-named student, I have received and read the ***Heads Up- Concussion in Sports - Fact Sheet for Parents, and the Sudden Cardiac Arrest Form,*** as well as the information above. I understand the nature and risk of sudden cardiac arrest, concussions and head injuries to student athletes, including the risks of continuing to play after suffering a concussion or head injury, and the procedures that will be followed before my student will be permitted to return to play.

| Parent/Legal Guardian Printed Name | Parent/Legal Guardian Signature | Date |
|---|---|---|

# INTER CITY CATHOLIC LEAGUE
# ATHLETIC CONTRACT

(PLEASE PRINT – USE INK)

YEAR _____ Boy_____ Girl_____

Last Name_____ First Name_____

Street Address_____

City_____ State_____ Zip Code_____

Phone_____ Grade_____ Birthdate_____

## I. PARENT AND ATHLETE

We, athlete and parent, understand that participation in athletics involves the possibility of a serious or even fatal injury. In consideration of our child's opportunity to participate in this program, we, the parents, individually and on behalf of our child, expressly assume any and all risks associated with and arising from such participation, including, but not limited to bodily and emotional injury, at practice, competitive events, and any other related activity, including transportation to and from any event by a volunteer. We hereby release the Diocese of Ft. Wayne/South Bend, ICCL, any parish and/or school sponsor and all of their agents from any and all liability for any such injury or damage. We have provided the required Emergency Medical Authorization to the coach with this Contract. We will abide by ICCL rules, the Parent's Code of Ethics and the direction of ICCL and game officials.

_____ _____

Athlete's Signature & date signed Parent's Signature and date signed

## II. PARENTS' CODE OF ETHICS

- I will place the emotional and physical well-being of my child ahead of any personal desire to win.
- I will demonstrate the Christian values of self-restraint, fair play, and sportsmanship in my treatment of others at every game, practice sessions, or other ICCL events.
- I will ask my child to treat all players, coaches, fans and officials with respect regardless of race, sex, or ability.
- I will demand a drug, alcohol, tobacco and weapon-free sports environment for my child and agree to assist by refraining from their possession and/or use at all ICCL events.
- I will do my best to make my child's involvement with youth sports a positive experience, while always remembering that the game is for the youth, not the adults.

I have read the above "Code of Ethics" and understand that my (our) failure to uphold any of these statements may lead to disciplinary action by the ICCL Board, which may include, but is not limited to, the forfeiture of my right to watch my child participate in ICCL athletic events.

_____ _____

Parent's Signature & date signed Parent's Signature & date signed