



**Saunders**  
MEDICAL CENTER

*Be Well.*

# Sports Physical Consent Form

Student Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone Number (        ) \_\_\_\_\_ School \_\_\_\_\_

***The above student has my consent to receive a sports physical,  
as required by his/her school, from Saunders Medical Center.***

Saunders Medical Center's HIPAA Notice of Privacy Practices is available on our website at [www.saundersmedicalcenter.com](http://www.saundersmedicalcenter.com); it is also available at the Saunders Medical Center Clinic. If you would like a copy, please check the box below and notice will be mailed to you.

***Your signature confirms that you have been given an opportunity to review our Notice of Privacy Practices.***

Yes, please mail the Notice of Privacy Practices to the above address.

03-305-21

\_\_\_\_\_  
*PLEASE PRINT Name of Parent or Guardian of Student*

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

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

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

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? 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? (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  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS<br>(Explain "Yes" answers at the end of this form.<br>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<br>(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?  |     |    |

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

**■ 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): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**SHARED EMERGENCY INFORMATION**

Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**■ PREPARTICIPATION PHYSICAL EVALUATION**

**ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

|   |            |           |  |
|---|------------|-----------|--|
| 1. Type of disability:  |            |           |  |
| 2. Date of disability:  |            |           |  |
| 3. Classification (if available):   |            |           |  |
| 4. Cause of disability (birth, disease, injury, or other):  |            |           |  |
| 5. List the sports you are playing:   |            |           |  |
|   | <b>Yes</b> | <b>No</b> |  |
| 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?              |            |           |  |
| 7. Do you use any special brace or assistive device for sports?   |            |           |  |
| 8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:**

|  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
| Atlantoaxial instability                                     |            |           |
| Radiographic (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 questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_  
 Signature of parent or guardian: \_\_\_\_\_  
 Date: \_\_\_\_\_

This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations.

## ■ 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: _____   | Weight: _____ |  |
| BP: _____ / _____ ( _____ / _____ )   | Pulse: _____  | Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL   | NORMAL        | ABNORMAL FINDINGS  |
| Appearance <ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul> |               |  |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>  |               |  |
| Lymph nodes   |               |  |
| Heart <sup>a</sup> <ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>  |               |  |
| Lungs   |               |  |
| Abdomen   |               |  |
| Skin <ul style="list-style-type: none"> <li>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>   |               |  |
| 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 <ul style="list-style-type: none"> <li>• Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>   |               |  |

<sup>a</sup> 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): \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA