



운동 경기/훈련 참가 전 신체검사

Pre-Participation Physical Evaluation for Athletics

Maryland State Department of Education
 Maryland State Department of Health
 MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
 Rockville, Maryland 20850

MCPS Form SR-8
 2019년 6월

운동 경기/훈련 참가 전 신체검사

학부모님 또는 후견인 여러분께:

9학년-12학년이 되는 학생은 Montgomery County Public Schools(MCPS) 학교 대항 운동경기과 학교 훈련 프로그램 참여를 위해 연례 참여 전 신체검사에 참여해야만 합니다. 7학년-8학년이 되는 학생은 MCPS 중학교 학교 대항 운동경기 프로그램에 참여하는 학생은 매2년마다 신체검사를 받아야만 합니다.

의사 등 자격증이 있는 의료담당자가 건강검진을 해야 합니다.

운동 경기/훈련 참가 전 신체검사는 네 가지 분야로 구성됩니다: 의료 기록 양식(1쪽과 2쪽), 신체검사 양식(3쪽), 장애 운동선수양식: 운동선수 기록(4쪽) 보충 자료과 의료적 적합성 양식(5쪽)

학생은 마지막 장인 5쪽(의료적 적합성 양식-5쪽)을 운동에 참석하기 전에 학교 또는 코치에게 제출해야 합니다. 의료 담당자가 처음 4장을 보관해야 합니다. (The authorized health care provider should retain the first four pages.)

학생인 운동선수가 연례 신체검사를 실시한 후에 심각한 상해 또는 수술을 받은 경우, 의료전문가가 작성한 승인 편지(clearance letter)를 운동에 참여하기 전에 제출해야 합니다.

이 양식의 건강 정보는 보건 담당자와 교육 담당자가 자녀의 교육에 필요할 경우에만 볼 수 있습니다.

신체검사는 학생 또는 학생 가족의 종교적인 신념에 상반될 경우에는 면제될 수도 있습니다. 이와 같은 경우, 학생 가족은 증명서류를 제출해야 합니다.

학생 운동선수가 학교에서, 연습 중, 또는 운동 경기 시 약 복용이나 처방이 필요할 경우, 각 약과 처방에 하나 당, 자격증이 있는 의료담당자가 작성한 약처방 또는 처방양식을 작성해야 합니다. 이 양식은 자녀의 학교에서 받으시거나 온라인(Montgomery County Public Schools-MCPS 웹사이트)을 통해 받을 수 있습니다. www.montgomeryschoolsmd.org: MCPS Form 525-12, 처방전 약 투약 허가서 제공과 면책권 동의서(Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement), MCPS Form 525-13, 투약허가서, 제공과 면책권 동의서(Authorization to Administer Prescribed Medication, Release and Indemnification Agreement), MCPS Form 525-14, 아나필락시스 진단받은 학생의 관리를 위한 응급처치: 에피네프린 자동 주사의 발주와 보증에 관한 동의(Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis: Release and Indemnification Agreement for Epinephrine Auto Injector). 자격증이 있는 의료담당자가 없거나 자녀가 특별한 개별 건강과정이 필요할 경우, 학교장이나 학교 양호 담당교사에게 연락합시다.

■ 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): _____

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 ≥ 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?		

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- 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"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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): _____ Date: _____

Address: _____ Phone: _____

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

■ 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:		
	Yes	No
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.

Please indicate whether you have ever had any of the following conditions:

	Yes	No
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.

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: _____

■ 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: _____
