## MONTGOMERY COUNTY PUBLIC SCHOOLS Rockville, Maryland 20850

#### PRE-PARTICIPATION PHYSICAL EVALUATION FOR ATHLETICS

Maryland State Department of Education
Maryland Department of Health

### PRE-PARTICIPATION PHYSICAL EVALUATION FOR ATHLETICS

To Parents or Guardians:

Students enrolled in grades 9-12 must have an annual pre-participation physical evaluation in order to participate in Montgomery County Public Schools (MCPS) interscholastic athletics and school conditioning programs. Students enrolled in grades 7-8 must have a medical evaluation every two years to participate in the MCPS middle school interscholastic athletics program.

The medical evaluation shall be performed by a licensed physician, a certified nurse practitioner, or a certified physician assistant under the supervision of a licensed physician.

The pre-participation physical evaluation consists of four parts: History Form (page 1), Supplemental History Form for Athletes with Special Needs (page 2), Physical Examination Form (page 3), and Clearance Form (page 4).

The student must turn in only the last page (CLEARANCE FORM—page 4) to the school or coach prior to participation. The physician should retain the first three pages.

When a student-athlete has experienced a significant injury, illness, or surgery after submitting the annual pre-participation physical evaluation, a clearance letter from a physician, nurse practitioner, or certified physician assistant under the supervision of a licensed physician is required to resume participation.

The health information submitted to the school will be available only to those health and education personnel who have a legitimate educational interest in your child.

## **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.)

Nata of Evam		- '				
Date of ExamName			Date of birth			
Name						
OUN Aye Uldue Sull			Oport(a)			
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking		
Do you have any allergies? ☐ Yes ☐ No If yes, please iden	ntify sne	ecific all	leray below.			
☐ Medicines ☐ Pollens	,		☐ Food ☐ Stinging Insects			
Explain "Yes" answers below. Circle questions you don't know the an	swers t	0.				
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No	
Has a doctor ever denied or restricted your participation in sports for			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
any reason?  2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?			
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections			28. Is there anyone in your family who has asthma?			
Other:			29. Were you born without or are you missing a kidney, an eye, a testicle			
Have you ever spent the night in the hospital?      Have you ever had surgery?			(males), your spleen, or any other organ?  30. Do you have groin pain or a painful bulge or hernia in the groin area?			
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?			
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?			
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?			
check all that apply: ☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?			
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?			
Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?			
during exercise?			41. Do you get frequent muscle cramps when exercising?			
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?			43. Have you had any problems with your eyes or vision?  44. Have you had any eye injuries?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?			
<ol> <li>Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including</li> </ol>			46. Do you wear protective eyewear, such as goggles or a face shield?			
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?			
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?			
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			49. Are you on a special diet or do you avoid certain types of foods?			
polymorphic ventricular tachycardia?  15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?			
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?			
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY  52. House your part and a magnetized partial?			
seizures, or near drowning?  BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period?  53. How old were you when you had your first menstrual period?		1	
17. Have you ever had an injury to a bone, muscle, ligament, or tendon	100		54. How many periods have you had in the last 12 months?			
that caused you to miss a practice or a game?			Explain "yes" answers here			
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?		<u> </u>				
I hereby state that, to the best of my knowledge, my answers to	ne abo	ve que	stions are complete and correct.			
Signature of athlete Signature of	f parent/g	uardian	Date			

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

180503

9-2681/0410

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date o	f Exam						
Name				Date of birth			
Sex	Aae	Grade	School				
	/pe of disability						
_	ate of disability						
	lassification (if available)						
_		isease, accident/trauma, other)					
5. LI	st the sports you are inte	rested iii piayiiig			Voc	No.	
6. D	6. Do you regularly use a brace, assistive device, or prosthetic?						
	7. Do you use any special brace or assistive device for sports?						
8. Do you have any rashes, pressure sores, or any other skin problems?							
9. Do you have a hearing loss? Do you use a hearing aid?    Do you have a hearing loss? Do you use a hearing aid?							
10. D	10. Do you have a visual impairment?						
11. D	o you use any special dev	vices for bowel or bladder function	on?				
	o you have burning or dis						
_	ave you had autonomic d						
			nermia) or cold-related (hypothermia) illne	ss?			
	o you have muscle spasti	•	dia atia n				
		ures that cannot be controlled by	medication?				
Explair	ı "yes" answers here						
Please	indicate if you have eve	er had any of the following.			1		
Atlant	oavial inetahility				Yes	No	
_	oaxial instability	al inetability			Yes	No	
X-ray	evaluation for atlantoaxia				Yes	No	
X-ray Disloc					Yes	No	
X-ray Disloc Easy t	evaluation for atlantoaxia ated joints (more than on				Yes	No	
X-ray Disloc Easy t	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen				Yes	No	
X-ray Disloc Easy t Enlarg Hepat	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen				Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo	evaluation for atlantoaxia ated joints (more than on pleeding jed spleen itits penia or osteoporosis ulty controlling bowel				Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu	evaluation for atlantoaxia ated joints (more than on bleeding jed spleen iitis penia or osteoporosis ulty controlling bowel ulty controlling bladder	ie)			Yes	No	
X-ray Disloc Easy t Enlarg Hepati Osteop Difficu Difficu Numb	evaluation for atlantoaxia ated joints (more than on bleeding jed spleen itis penia or osteoporosis jity controlling bowel jity controlling bladder ness or tingling in arms o	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Difficu Numb	evaluation for atlantoaxia ated joints (more than on bleeding jed spleen itis penia or osteoporosis julty controlling bowel julty controlling bladder ness or tingling in arms on ness or tingling in legs or	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepati Osteo Difficu Numb Numb	evaluation for atlantoaxia ated joints (more than on bleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms of ness or tingling in legs or ness in arms or hands	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr	evaluation for atlantoaxia ated joints (more than on bleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms of ness or tingling in legs or ness in arms or hands ness in legs or feet	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepati Osteol Difficu Difficu Numb Weakr Weakr Recen	evaluation for atlantoaxia ated joints (more than on pleeding jed spleen itits penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms o ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepati Osteol Difficu Numb Numb Weakr Weakr Recen Recen	evaluation for atlantoaxia ated joints (more than on pleeding jed spleen itits penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms of ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Difficu Numb Weakr Weakr Recen Recen Spina	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itits penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itits penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloc Easy t Enlarg Hepat Osteo Difficu Numb Numb Weakr Recen Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on oleeding jed spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands			Yes	No	
X-ray Disloce Easy to Enlarg Hepat Osteol Difficu Numb Weakr Weakr Recen Spina Latex	evaluation for atlantoaxia ated joints (more than on obleeding led spleen iitis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy	or hands r feet	's to the above questions are complete	and correct.	Yes	No	
X-ray Dislocc Easy to Enlarge Hepat Osteol Difficut Numb Numb Weaking Recens Spina Latex  Explair	evaluation for atlantoaxia ated joints (more than on obleeding led spleen itis penia or osteoporosis alty controlling bowel alty controlling bladder ness or tingling in arms on ness or tingling in legs or ness in arms or hands ness in legs or feet at change in coordination at change in ability to wall bifida allergy  1 "yes" answers here	or hands r feet		and correct.	Date	No	

### PHYSICAL EXAMINATION FORM

Name							Date of birth
<ul><li>Have you ever take</li><li>Do you wear a sea</li></ul>	uestions on more ser ed out or under a lot of ad, hopeless, depress your home or reside d cigarettes, chewing days, did you use ch ol or use any other die an anabolic steroids of an any supplements t t belt, use a helmet, a	of pressure ed, or anx nce? tobacco, ewing tob rugs? r used any o help you and use co	e? ious? snuff, or dip? acco, snuff, or dip? y other performance suppler gain or lose weight or impr		ance?		
EXAMINATION							
Height		Weight		☐ Male	☐ Female		
BP /	( /	)	Pulse	Vision R		L 20/	Corrected  Y N
MEDICAL					NORMAL		ABNORMAL FINDINGS
arm span > height, l	phoscoliosis, high-archyperlaxity, myopia, N		te, pectus excavatum, arachi insufficiency)	nodactyly,			
<ul><li>Eyes/ears/nose/throat</li><li>Pupils equal</li><li>Hearing</li></ul>							
Lymph nodes							
<ul> <li>Heart <sup>a</sup></li> <li>Murmurs (auscultati</li> <li>Location of point of</li> </ul>			va)				
Pulses  • Simultaneous femor	al and radial pulses						
Lungs	•						
Abdomen							
Genitourinary (males or	nly) <sup>b</sup>						
<ul><li>Skin</li><li>HSV, lesions suggest</li></ul>	tive of MRSA, tinea co	orporis					
Neurologic °							
MUSCULOSKELETAL							
Neck Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							
Hip/thigh							
Knee							
Leg/ankle							
Foot/toes Functional							
<ul> <li>Duck-walk, single le</li> </ul>	g hop						
Consider GU exam if in priva	te setting. Having third p	arty preser	normal cardiac history or exam. It is recommended. Ing if a history of significant concu	ussion.			
☐ Cleared for all sports☐ Cleared for all sports		ith recom	mendations for further evalu	ation or treatmen	t for		
□ Not cleared							
☐ Pendin	g further evaluation						
☐ For any	, sports						
	•						
	•						
articipate in the sport	(s) as outlined abou nlete has been clear	e. A copy ed for pa	of the physical exam is or	n record in my of	fice and can be ma	ade available to th	pparent clinical contraindications to practice and ne school at the request of the parents. If condi- ed and the potential consequences are completely
ame of physician (print	/type)						Date
Address							Phone

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Signature of physician \_

, MD or DO

## **CLEARANCE FORM**

Name		Sex 🗆 M 🗆 F Age	Date of birth
☐ Cleared for	all sports without restriction		
☐ Cleared for	all sports without restriction with recommend	dations for further evaluation or treatment for	
□ Not cleared	j		
	Pending further evaluation		
	For any sports		
	For certain sports		
	Reason		
Recommendat	ions		
I have exam	ined the above-named student and co	ompleted the preparticipation physical evalu	ation. The athlete does not present apparent
clinical cont	raindications to practice and particip	ate in the sport(s) as outlined above. A copy	of the physical exam is on record in my office
			r the athlete has been cleared for participation,
	-	problem is resolved and the potential conse	equences are completely explained to the athlete
(and parents	s/guardians).		
Name of physic	cian/nurse practitioner (print/type)		Date
			Phone
			Title
EMERGEN	CY INFORMATION		
Allergies			
Other informat	ion		