SOUTHERN BONE & JOINT SPECIALISTS SPORTS MEDICINE & REHAB

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Enterprise, Alabama 36330
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345 Healthwest Drive
Dothan, Alabama 36303

MEDICAL SCREENING EXAMINATION FORM

DATE_____ School or Organization _____

Name _____
Last First Middle

Address _____
Street

_____
City State Zip

Phone (_____) _____ S.S. #_____

Parents Work Phone (_____) _____

Date of Birth_____ Age_____ Sex_____

Name of Family Physician _____

CONSENT FOR SCREENING: The undersigned agrees to submit to a medical screening examination for athlete participation. I understand that this is a screening examination designed to identify common conditions or infirmities that would limit or prevent participation in athletic activities. This examination is not intended to be comprehensive and may not detect some types of latent or hidden medical conditions.

This is to certify that I have read and understand the above information and have given my permission and consent to the screening for athletic participation.

I hereby state that, to the best of my knowledge, the answers I have given on the medical examination are true and correct.

_____ _____
Student Athlete's Signature Date

_____ _____
Parent's Signature Date

SOUTHERN BONE &
JOINT SPECIALISTS

RELEASE OF MEDICAL INFORMATION & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

In order to protect the privacy and security of individual health information, Southern Bone & Joint Specialists is complying with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule. Our **Notice of Privacy Practices** is included in this packet.

Be sure to sign and return this form along with your physical form in order for your physical exam to be done.

RELEASE OF MEDICAL INFORMATION:

I_____understand that participation in a sports program is a privilege. Along with the participation, there is adherent danger and possibilities of injury. In the event of an injury or any recognition of abnormalities found within the physical exam, I authorize Southern Bone & Joint Specialists to discuss my condition with other medical professionals involved with the treatment of my condition including referring physicians. I understand that my condition may also need to be discussed with my school officials.

Communication from Southern Bone & Joint Specialists will be with the student, their family or guardian and if necessary any of the following: School Athletic Director, Head Sports Coach, Assistant Coaches, school insurance coordinator, the Principal, Primary Care Physician, Pediatrician and Referring Physicians.

It is not the practice of Southern Bone & Joint Specialists, to release individual health information to the media on any sports injury or health status. All such inquiries will be referred to the school or Head Sports Coach.

I acknowledge and agree with the above stated paragraphs and the **Notice of Privacy Practices** included in this packet.

_____ _____

Print Name of Student

Parent Signature

_____

Student Signature

_____

Date

Please list below the names of any individuals who we may disclose any medical and/or account billing information on your behalf. These people will be allowed to act as your personal representative.

NAME	RELATIONSHIP
_____	_____
_____	_____

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION
Preparticipation Physical Evaluation Form

History

Date _____

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Sport _____

Explain "Yes" answers below:		Yes	No
1.	Has a doctor ever restricted/denied your participation in sports?	☐	☐
2.	Have you ever been hospitalized or spent a night in a hospital?	☐	☐
	Have you ever had surgery?		
3.	Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☐
4.	Are you presently taking any medications or pills (prescription or over-the-counter)?	☐	☐
5.	Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☐
6.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☐
	Do you tire more quickly than your friends during exercise?	☐	☐
	Have you ever had high blood pressure?	☐	☐
	Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
	Does anyone in your family have a heart condition?	☐	☐
	Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
7.	Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
8	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out or unconscious?	☐	☐
	Have you ever had a seizure?	☐	☐
	Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
9.	Have you ever had heat or muscle cramps?	☐	☐
	Have you ever been dizzy or passed out in the heat?	☐	☐
10.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
	Do you take any medications for asthma (for instance, inhalers)?	☐	☐
11.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses or contacts or protective eye wear?	☐	☐
13.	Have you ever had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?		
14.	Have you had a medical problem or injury since your last evaluation?	☐	☐
15.	Have you ever been told you have sickle cell trait?	☐	☐
	Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
16.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	☐	☐
	☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle		
	☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot		
17	When was your first menstrual period? _____		
	When was your last menstrual period? _____		
	What was the longest time between your periods last year? _____		

Explain "Yes" answers:

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Student Name:

_____

Rule 1, Sec. 14 - In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grades 7-12). The AHSAA Physicians Certificate (Form 5) must be used. **A physical exam will satisfy the requirement for one calendar year from the date of the exam.**

Preparticipation Physical Evaluation

Height _____ Weight _____ BP ____ / ____ Pulse _____

Vision R 20/____ L 20/____ Corrected: Y N

LIMITED		Normal	Abnormal Findings				
	Cardiovascular						
	Pulses						
	Heart						
	Lungs						
	Skin						
COMPLETE	E.N.T.						
	Abdominal						
	Genitalia (males)						
	Musculoskeletal						
	Neck		Flex	EXT	ROT		
	Shoulder		Delt	Sup	IR	ER	ROM
	Elbow		Flex	EXT			
	Wrist		Flex	EXT	PRO	SUP	
	Hand		Grip				
	Back		Sco	Flex	EXT		
	Knee		Hams	Hipflex	QUAD	Exam	
	Ankle		HC				
	Foot						
	Other						

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for:

C. Not cleared for: ❑ Collision

❑ Contact

❑ Noncontact: ____ Strenuous ____ Moderately Strenuous ____ Nonstrenuous

Due to: _____

Recommendation: _____

_____

_____

Name of Physician: _____ Date _____

Address _____ Phone _____

Signature of Physician _____, M.D. or D.O.