

Sports Physicals!

\$15.00

Thursday, June 17th

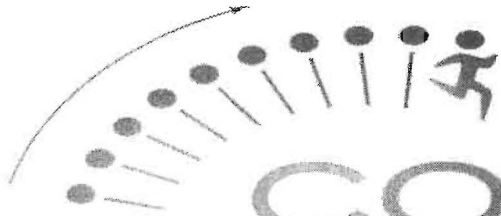
6 – 8 PM

CHS Gymnasium

(Provided by the physicians of the
Center for Orthopedic Surgery & Sports Medicine)

Athletes must have a signed consent form at time of
exam.

Forms available online, in Athletic Training Room or
from CHS Coaches.



COSSM

**CENTER FOR ORTHOPEDIC SURGERY
& SPORTS MEDICINE**

at St Elizabeth's Hospital

180 South 3rd, Suite 100
Belleville, IL 62220
(618) 641-5800
(618) 641-5825 FAX

CONSENT FOR PHYSICAL EVALUTATION AND TREATMENT

I, _____, hereby give consent to St. Elizabeth's Hospital and the Center for Orthopedic Surgery and Sports Medicine staff to complete a physical evaluation, diagnostic tests, to include radiology exams and laboratory tests, and treatment on my child, _____ in the event of musculoskeletal injury or medical condition as a result of participating in my child's school athletic program.

Signature

Date

Witness

Date

Physical Examination

Height _____ Weight _____ Blood Pressure _____
 Pulse: resting _____ 15 hops _____ after 2 minutes _____
 Visual Acuity: Eyes (R) 20/ _____ w/o glasses _____ (L) 20/ _____ w/ glasses _____

Other Testing	Normal	Abnormal Findings
1. General	_____	_____
2. Skin	_____	_____
3. HEENT	_____	_____
4. Teeth (Dental Exam)	_____	_____
5. Neck	_____	_____
6. Lungs	_____	_____
7. Heart (Sit and Stand)	_____	_____
8. Abdomen	_____	_____
9. Genitalia	_____	_____
10. Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Shin/Calf	_____	_____
Ankle/Leg	_____	_____
Foot	_____	_____
11. Peripheral Pulses	_____	_____
12. Neurologic	_____	_____
13. Mental Status	_____	_____
14. Marfan Screen	_____	_____

Other Tests (optional)

_____ Auditory _____ U/V _____ EKG
 _____ % Body Fat _____ Drug Screen _____ Chest X-Ray
 _____ Hgb/Hct _____ SMAC _____ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes _____ No _____ Limited _____

Additional Comments:

Examination Date _____ Physicians Signature _____
 Physician's Assistant Signature* _____
 Advanced Nurse Practitioner Signature* _____

* effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Student's Name _____ School Name _____

Consent Form to self administer asthma medication
 (not needed if current form is already on file with school)

Parent Consent

I, _____, do hereby give my son/daughter, _____, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent Signature _____ Date _____

Physician Consent

As a patient under my care, _____, is prescribed to self-administer the following asthma medication.

Medication _____

Purpose _____

Dosage _____

Time/Special Circumstances _____

Physician Signature _____ Date _____

IHSA Steroid Testing Policy Consent to Random Testing

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing dietary supplements of teams and individuals qualifying for state finals competition.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_list-2007-08.pdf.

Signature of student-athlete _____ Date _____
 Signature of parent-guardian _____ Date _____





Preparticipation Examination

To be completed by athlete or parent prior to examination.

Name _____ Sport/Position _____
Last First Middle

Social Security Number _____ School Year _____

Address _____

City/State _____ Phone No. _____

Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____

Address _____

Phone No. _____

Person to contact in case of emergency _____

Phone No. _____

Family Doctor _____ City/State _____

Phone No. _____

Past Medical History

Yes No If yes, please explain (what, where, when)

- 1. Presently taking medication (including birth control pills)?
- 2. Have you been diagnosed with asthma?
- 3. Have you been prescribed by a physician to use any asthma medication?
- 4. Do you have a current consent form to self-administer the asthma medication on file with your school?
- 5. Allergic to medicine, foods, bee stings?
- 6. Wears any appliances—glasses, contact lenses?
- 7. History of braces, chipped teeth, bridges?
- 8. Has ongoing medical problem?
- 9. Had serious or significant illness in past?
- 10. Any past surgical operations, accidents, non-sports or related injuries?
- 11. Any past injuries directly related to sports?
- 12. Any hospitalization not explained above?
- 13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?
- 14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?
- 15. Heart
Have you ever passed out during or after exercise?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?

- Have you had high blood pressure or high cholesterol?
- Have you ever been told you have a heart murmur?
- Has any family member or relative died of heart problems or of sudden death before age 50?
- Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?
- Has a physician ever denied or restricted your participation in sports for any heart problems?
- Has anyone in your family had a heart attack before the age of 50?
- 16. Head and Nerve
Have you ever had a head injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs or feet?
Have you ever had a stinger, burner or pinched nerve?
- 17. Last tetnus shot? Date _____
- 18. Last eye exam? Date _____
- 19. Last menstrual period (if women) Date _____

Personal Habits

Yes No

- 1. Smoking/smokeless tobacco
- 2. Alcohol/non-medical drugs: marijuana, cocaine, etc
- 3. Steroids
- 4. Eating Disorders - weight loss or gain?

Review of systems (Please check if you have any problems with any of the following areas of your body)

- Skin Lungs Shoulders, Arms, Hands
- Head Heart Hips, Legs, Feet
- Eyes Abdomen Muscles—Strength, Feeling
- Ears Back Mental, Emotional
- Nose Urination, Fatigue
- Mouth/Throat Bowel Control Other: What?
- Nutrition, Genital (including menstrual for women)
- Weight Control
- Neck

I certify that the above information is correct to the best of my knowledge.

Student Signature _____

Parent/Guardian Signature _____

Both Student And Parent/Guardian Signatures Are Mandatory