■ 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?

Indicate: 0-Not at all 1-Several days 2-Over half the days 3-Nearly every day

Feeling nervous, anxious, or on edge: ☐

Not being able to stop or control worrying: ☐

Little interest or pleasure in doing things: ☐

Feeling down, depressed, or hopeless: ☐

(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?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here (Start typing below):

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

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: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (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 • 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

615 Sheridan Street
Port Townsend, WA 98368
www.JeffersonCountyPublicHealth.org

JEFFERSON SCHOOL BASED HEALTH CENTERS

For more information contact Jefferson County Public Health (360) 385-9400

GENERAL CONSENT FOR SERVICES

Student Name (please print) _____ Date of Birth _____

I give permission to Jefferson School Based Health Center to perform such medical and therapeutic procedures as may be professionally necessary or advisable for me (or my child's) health screening, diagnosis and treatment. I understand that a patient record will exist for each student. This consent allows services and information to be authorized and shared between Jefferson Healthcare, Jefferson County Public Health and MCS Counseling Services within the clinic.

I understand the following types of services are offered through the School Based Health Clinic (SBHC):

- ◊ Routine physical exams, including sports physicals
- ◊ Diagnosis and treatment of acute and chronic illness
- ◊ Laboratory tests
- ◊ Reproductive health services, e.g. counseling, education, exams, and referrals
- ◊ Immunizations
- ◊ Health education, counseling, and wellness promotion
- ◊ Nutrition and health education, wellness counseling
- ◊ Mental health services offered by MCS Counseling Services
- ◊ Referral for health care services which cannot be provided at the School Based Health Center
- ◊ Dental services, referrals

STATEMENT OF STUDENT CONFIDENTIALITY AND RIGHTS

Services provided at Jefferson School Based Health Center (SBHC) must have a signed consent form from a parent or legal guardian before health services are provided to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. According to the law, minors may provide their own consent for alcohol and drug treatment and mental health treatment at age 13 or older and reproductive health care at any age. If necessary, the SBHC will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

The youth's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), alcohol and drug treatment, or mental health counseling.

When a person consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- ◊ If the client gives us permission through a signed release of information.
- ◊ If student shows risk of suicidal behavior.
- ◊ If student plans to do serious bodily harm to another person.
- ◊ If student has a life threatening health problem **and is under 18 years of age.**
- ◊ If there is reason to suspect abuse or neglect. This *may* include any sexual contact with a minor (any person under the age of 18 years) by a person over 18 years old or where there is a three (3) year or greater age difference.

All information and services received are confidential.
The School Based Health Center encourages all students to involve their parents or guardians in their health care decisions whenever possible. This consent expires when the student is no longer enrolled in the Port Townsend, Chimacum or Quilcene School District.

Student Signature _____ DOB _____ Phone _____ Date _____

Parent or Legal Guardian Name (Please Print) _____ Relationship to Student _____

Parent or Legal Guardian Signature _____ Phone _____ Date _____