Youth and Community Sports
PRE-PARTICIPATION PHYSICAL EVALUATION

PHYSICAL EVALUATION: Prior to any student participating in any Practices, Scrimmages, and/or YOUTH/COMMUNITY ORGANIZATION'S Games, the student is required to (1) complete a Pre-Participation Physical Evaluation (PPE); and (2) have the appropriate person(s) complete the first two Sections of the PPE Form (parent/guardian). Upon completion of Page 1 and 2 by the parent/guardian; and Page 3 by an Authorized Medical Examiner (AME), those Sections must be turned in to the YOUTH/COMMUNITY ORGANIZATION'S Medical Representative for retention by the board. The PPE may not be authorized earlier than June 1st and shall be effective up to including the YOUTH/COMMUNITY ORGANIZATION'S season (includes pre-season, in-season and post-season).

PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

EMERGENCY INFORMATION

Parent's/Guardian's Name_____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier_____ Policy Number_____

Address _____Telephone # ( ) _____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( ) _____

Student's Allergies_____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware_____

_____

_____

Student's Prescription Medications_____

_____

Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in YOUTH/COMMUNITY ORGANIZATION'S Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care.

Parent's/Guardian's Signature _____Date____/____/_____

Student's Name _____ Age_____ Grade_____

HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐

	Yes	No
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you ever had a herpes skin infection?	☐	☐
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Do you experience dizziness and/or headaches with exercise?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you unhappy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY	☐	☐
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period?	_____	
49. How many periods have you had in the last 12 months?	_____	
50. Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____Date____/____/___

PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's pre-participation physical evaluation (PPE) and turned in to the YOUTH/COMMUNITY ORGANIZATION'S Medical Representative for retention by the board.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Scrimmages, and/or YOUTH/COMMUNITY ORGANIZATION'S Games as consented to by the student's parent/guardian Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Authorized Date of PPE ___/____/___

Coordinated Health
Better. Together.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO SCHOOLS AND/OR TO ANY FAMILY MEMBERS

I authorize Coordinated Health Holding Company LLC, CHS Professional Practice, Inc., CH Hospital of Allentown, LLC, Coordinated Health Orthopedic Hospital, LLC, and/or Coordinated Health of Greater New Jersey, LLC, their affiliates, and/or any assistants that they may select (which may include physicians, residents, fellows, medical students, physician's assistants, nurses, technicians administrators, and/or other employees) (collectively and individually known as "Coordinated Health") to disclose the protected health information referenced in this Authorization to athletic directors, coaches, nurses, guidance counselors, teachers, and/or administrators at the following school and/or to any family members of the below identified student-athlete who are present at an event where the student-athlete is injured and/or receives care from a Coordinated Health provider:

_____

Print Name of School and/or Specific Family Members

The protected health information to be disclosed is the entire designated record set and/or information contained therein, which may include (but is not limited to) historical, examination, diagnostic testing and results thereof, drug/alcohol, mental health and/or HIV information and/or drug/alcohol testing results, except the following: NONE.

_____

If an exception applies, cross out "None" and specify the exception(s)

This protected health information is being disclosed at the request of the undersigned.

This Authorization shall be in effect for twelve (12) months from the below date. I understand that I have the right to revoke this Authorization in writing at any time by sending written notification to: Coordinated Health Privacy Officer, Coordinated Health, 3435 Winchester Rd., Allentown, PA 18104. I understand that Coordinated Health shall need a reasonable time to process my revocation. I agree that five (5) business days after Coordinated Health receives said revocation is a reasonable period of time for Coordinated Health to process my revocation. Consequently, I understand that my revocation will not be effective until five (5) business days after it is received by Coordinated Health.

I understand that Coordinated Health may condition my examination/evaluation on whether I execute this Authorization if the primary purpose of the creation of this protected health information is for disclosure to the aforesaid school (e.g., for participation in athletics). Otherwise, Coordinated Health shall not condition its medical care of the below identified patient on whether I execute this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by Federal or State law.

I hereby release Coordinated Health and/or their officers, representatives, employees and/or agents from any and all claims related to their use or disclosure of information pursuant to this Authorization. This release shall apply to my heirs, beneficiaries, successors and/or assignees.

By my signature below, I acknowledge that I have received a copy of this document and a copy may be used as if it were an original.

_____	_____	_____
Student's Name	Parent/Guardian's Signature	Date