HISTORY FORM *Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out the form prior to visit.

Name _____ Age: _____ Date of Birth: _____ Grade: _____

Sex _____ School _____ Sport(s) _____ Sports Experience in years _____

List past and current medical conditions:	Have you ever had surgery? If yes list all past surgical procedures:
List all current prescriptions, OTC medicines, and supplements (herbal & nutritional):	List all of your allergies (medicines, pollens, food, stinging insects, etc.):

Over the past 2 weeks, how often have you been bothered by any of the following (circle)	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Mental Health: A sum of >= 3 for questions 1+2, or 3+4, is considered positive

	GENERAL QUESTIONS	Yes	No
1.	Do you have any concerns 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 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 told you that you have any heart issues?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?		
9.	Do you get light headed or feel shorter of breath more 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 implanted defibrillator before age 35?		
	BONE AND JOINT QUESTIONS	Yes	No
14.	Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon?		
	MEDICAL QUESTIONS		
15.	Have you been diagnosed with COVID-19?		
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)?		

		Yes	No
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problem?		
21.	Have you ever had numbness, tingling, weakness in your arms or leg or been unable to move your arms or legs after being hit or falling?		
22	Have you ever become ill during exercising in the heat?		
23.	Do you or someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have problems with your eyes or vision?		
25.	Do you worry much about your weight?		
26.	Are you trying or has anyone recommended 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?		
29.	Any food allergies ?		
30.	Any Sports induced medical conditioning ?		

Answer "Yes" if it ever occurred. Explain "yes" answers here:

SCHOOL QUALIFIED HEALTHCARE PROFESSIONAL (QHP): (RN/ATC)
If "yes is answered to any of the above, or "3+ for mental health questions. since the athlete was last cleared for athletic participation, a referral and clearance by the athlete's primary care provider are required.

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

Signature of Athlete: _____ Date: _____ Signature Parent/Guardian: _____ Date: _____

Rev 4/1/2023

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, 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 bell, 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, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[1] • Murmurs (auscultation standing, supine, +/- Valsalva)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL		
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		

[1]Consider ECG, echocardiogram, echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of these.

HEALTHCARE PROVIDER (MD/DO, NP, PA): THIS FORM [pg4] MUST BE USED IN CONJUNCTION WITH THE MEDICAL HISTORY FORM [pg3] AND MEDICAL CARD [pg5]. THIS FORM [pg. 4] MUST BE SIGNED BY HEALTH CARE PROVIDER (MD/DO, NP, PA).

Comments:

_____

Not Cleared _____ Cleared without restrictions _____ Cleared with the following restrictions: _____

Name of Health Care Provider (MD/DO, NP, PA) print or type:_____ Date of Exam:_____

Address:_____ Phone:_____

Signature of Health Care Provider (MD/DO, NP, PA):_____ Date of Clearance:_____

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

Section 1: Contact/Personal Information

Name: _____ Sport(s): _____

Age: _____ Birthdate: _____ School: _____ Grade: _____

Guardian Name: _____

Address: _____

Phone: (H) _____ (W): _____ (C): _____ (P) _____

Other Authorized Person To Contact In Case Of Emergency:

Name: _____ Phone(s): _____

Name: _____ Phone(s): _____

Preference Of Physician (And Permission To Contact If Needed): _____

Name: _____ Phone: _____

Hospital Preference: _____ Insurance: _____

Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information

Medical Illnesses: _____

Last Tetanus (Mo/Yr): _____ Allergies: _____ Braces/Splints: _____

Medications: _____

(Any medication(s) that may need to be taken during competition require a physician's note.)

Previous Head/Neck/Back Injury: _____

Heat Disorder, Or Sickle Cell Trait: _____

Previous Significant Injuries: _____

Any Other Important Medical Information: _____

Section 3: Consent for Athletic Conditioning, Training, and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary healthcare treatment, including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency, I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature: _____ **Date:** _____

Athlete's Signature: _____ **Date:** _____

Section 4: Verification of Clearance for Participation

Comments: _____

_____

Qualified Health Care Professional's (QHP) Signature after reviewing PPE: _____ **(RN/ATC)**

Date: _____

For School Office Use Only: *This card is valid from April 1, 20 _____ through June 30, 20 _____*

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school nurse, athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kit. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: _____ ***Name of School QHP:*** _____