



**SHS VIKINGS**  
**ATHLETICS**  
**PHYSICAL PACKET**



Dear Parents and Guardians,

Welcome to Spartanburg High School Athletics. We are excited for the season to begin! Before your student athlete can participate in tryouts, practices, or games a complete pre participation physical packet has to be completed and turned into our Athletic Trainers. A physical dated after 4/1/2021 will be in effect until the last school day of the 2021-2022 school year. The reason of this letter is to go over each page in the physical packet and clarify their purpose.

- **Page 1- Preparticipation Physical Evaluation-History Form:** This page is to be filled out completely and signed by both the student athlete and the parent/guardian. The doctor uses this form at the time of the exam to make sure the student athlete has no pre-existing or underlying concerns to play sports.
- **Page 2- Preparticipation Physical Evaluation-Physical Form:** This form needs to be filled out in its entirety at the time of the evaluation. Please make sure that the doctor fills it out completely. At the bottom they must check if the athlete has any restrictions for athletic participation along with their signature, date, phone number and address.
- **Page 3- Parent Permission for Activity, Treatment and Insurance:** This page is to be filled out and signed by the parents/guardians and student athlete. This provides correct contact information in the event a parent needs to be reached. It also shows that everyone understands the risk for injuries and illnesses when playing in sports. In the unfortunate event that your student athlete does sustain an injury while participating in sports at Spartanburg High School and needs to be seen by a physician, we do have Secondary Athletic Injury Insurance Policy to help with some cost after your primary insurance. Please note that it is NOT guaranteed that our policy will pay 100% of the bill after your primary insurance. The remaining of medical expenses are the responsibility of the parent/guardian. If you have any questions regarding the secondary insurance policy, please reach out to April Taylor, MS, ATC at the contact info below.
- **Page 4- Parent/Student-Athlete Concussion Statement:** SCHSL requires all parents and student athletes to be aware of the risk, signs and symptoms, and side effects of a concussion. This page states you understand this and what your role is if you suspect you or a teammate has concussion
- **Page 5 and 6- Concussion Information Sheets-** These pages are giving you detailed information on what a concussion is, signs and symptoms and what to do if you do sustain a head injury. These are for you to keep.

Please fill out all pages discussed and return to our Athletic Training Staff. Please do not hesitate to reach out if you have any questions. Go Vikings!

*April Taylor, MS, ATC*

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Todd Staley

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# 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: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

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): \_\_\_\_\_

General Questions			Medical Questions				
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.			Yes	No	Yes	No	
1. Do you have any concerns that you would like to discuss with your provider?					16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Has a provider ever denied or restricted your participation in sports for any reason?					17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
3. Do you have any ongoing medical issues or recent illness?					18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
Heart Health Questions About You			Yes	No	19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?					20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?					21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?		
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?					22. Have you ever become ill while exercising in the heat?		
7. Has a doctor ever told you that you have any heart problems?					23. Do you or someone in your family have sickle cell trait or disease?		
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.					24. Have you ever had or do you have any problems with your eyes or vision?		
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?					25. Do you worry about your weight?		
10. Have you ever had a seizure?					26. Are you trying to or has anyone recommended that you gain or lose weight?		
Health Questions About Your Family			Yes	No	27. Are you on a special Diet or do you avoid certain types of foods?		
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?					28. Have you ever had an eating disorder?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?					Females Only		
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?					29. Have you ever had a menstrual period?		
Bone and Joint Questions			Yes	No	30. How old were you when you had your first menstrual period?		
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 game or practice?					31. When was your most recent menstrual period?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?					32. How many periods have you had in the past 12 months?		

Explain a "Yes" answer here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 \_\_\_\_\_

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# Preparticipation Physical Evaluation - Physical Form

\_\_\_\_\_  
 Last Name                                      First Name                                      Middle Initial                                      Date of Birth

<b>Examination</b>						
Height:		Weight:				
BP:	/	(	/	)	Pulse:	_____
Vision:			R 20/	L 20/	Corrected ___ Yes ___ No	

Medical	Normal	Abnormal Findings
<b>Appearance:</b> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
<b>Eyes / Ears / Nose / Throat</b> - Pupils equal / Hearing		
<b>Lymph Nodes</b>		
<b>Heart</b> - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
<b>Lungs</b>		
<b>Abdomen</b>		
<b>Skin</b> - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
<b>Neurologic</b>		
<b>Musculoskeletal:</b>		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

### Preparticipation Physical Evaluation

- Medically eligible for all sports without restriction.
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: \_\_\_\_\_
- Medically eligible for certain sports: \_\_\_\_\_
- Not medically eligible pending further evaluation.
- Not medically eligible for any sports.
- Recommendations: \_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete had been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_ MD, DO, NP, or PA

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# SPARTANBURG DISTRICT 7 PARENT PERMISSION

(PLEASE PRINT)

Athlete's Name \_\_\_\_\_ School \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact (if parents cannot be notified): Name \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Do you have health insurance? Yes / No      Do you have Medicaid? Yes / No      Medicaid # \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

\*Spartanburg School District 7 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay secondarily to the athlete's primary health insurance (Note: This is not a 100% coverage policy before or after primary insurance). In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing Spartanburg District 7, the athlete should seek the attention of the sports medicine staff as soon as possible. The Athletic Trainer (high school) or school official (middle school) will fill out the top portion of the insurance claim form. The parent/guardian should complete the claim form, follow the attached directions and return to claim form to the Athletic Trainer (Note: The claim must be filed within 90 days of injury.) I understand this information and will notify the head athletic trainer prior to the doctor's appointment if I require a claim form for an injury that meets the above requirements.

### CONSENT OF MEDICAL TREATMENT / RELEASE OF INFORMATION

I/We give consent for certified athletic trainers (SSD7 employees and SRHS employees), coaches, and physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to physicians, certified athletic trainers, and/or appropriate healthcare professionals to attend to my son/daughter. It is understood the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for our son/daughter to be evaluated and treated by the school's certified athletic training staff and/or team physicians if he/she becomes injured while participating as an athlete for SSD7 during the school year. I/We also authorize the school's sports medicine staff to be given medical information concerning my son/daughter by a physician or their staff. Likewise, the school's sports medicine staff may release medical information to physician's offices, coaching staff, nurses, administrators and faculty within Spartanburg District 7 as they see appropriate. I also commit to reporting ALL injuries to the sports medicine staff including but not limited to any symptoms related to a concussion. I also understand the sports medicine staff will follow a return to play protocol for all injuries. I understand that the data acquired during these evaluations may be used for research purposes. In consideration for the care and treatment provided by Athletic Trainers, Physicians, Coaches and Nurses, I hereby release and hold harmless the medical care givers from and against any claim, cause of action or other expense arising out of the services provided by the medical team, except to the extent that such claims arise out of the District's gross negligence or intentionally injurious acts.

### PARENT'S PERMISSION & ACKNOWLEDGEMENT OF RISK FOR SON OR DAUGHTER TO PARTICIPATE IN ATHLETICS

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events. With my permission I understand there is always a risk of injuries and/or illnesses that can occur during athletic participation to include competitions, practices, meetings, locker rooms, travel to and from athletic events, etc.

Student's Signature \_\_\_\_\_ Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_

# **PARENT/STUDENT-ATHLETE CONCUSSION STATEMENT**

**\_\_\_ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.**

**\_\_\_ A concussion is a brain injury, which I am responsible for reporting to my athletic trainer.**

**\_\_\_ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.**

**\_\_\_ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.**

**\_\_\_ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer.**

**\_\_\_ I will not return to play in a game or practice if I have received a blow to my head or body that results in concussion-related symptoms.**

**\_\_\_ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.**

**\_\_\_ In rare cases, repeat concussions can cause permanent brain damage, and even death.**

**\_\_\_ I have read and understand the Concussion Fact Sheet for Parents and Student-Athletes.**

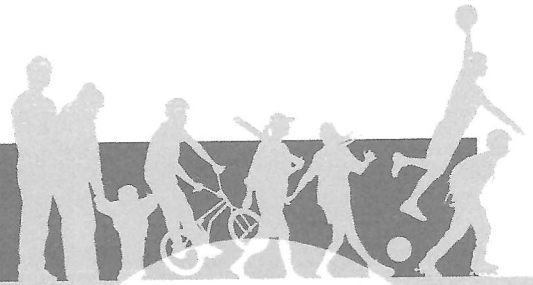
**Parent/Guardian Name:** \_\_\_\_\_  
(Please Print)

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Student Name:** \_\_\_\_\_  
(Please Print)

**Student/Athlete Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

## CONCUSSION INFORMATION SHEET



**HEADS UP  
CONCUSSION**

This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

### WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.



### HOW CAN I SPOT A POSSIBLE CONCUSSION?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just “don’t feel right” after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

#### SIGNS OBSERVED BY PARENTS OR COACHES

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows mood, behavior, or personality changes.
- Can’t recall events prior to or after a hit or fall.

#### SYMPTOMS REPORTED BY CHILDREN AND TEENS

- Headache or “pressure” in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not “feeling right,” or “feeling down.”

## WHAT ARE SOME MORE SERIOUS DANGER SIGNS TO LOOK OUT FOR?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

## WHAT SHOULD I DO IF MY CHILD OR TEEN HAS A POSSIBLE CONCUSSION?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

## HOW CAN I HELP KEEP MY CHILDREN OR TEENS SAFE?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - » Work with their coach to teach ways to lower the chances of getting a concussion.
  - » Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - » Ensure that they follow their coach's rules for safety and the rules of the sport.
  - » Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.



TO LEARN MORE GO TO >> [cdc.gov/HEADSUP](http://cdc.gov/HEADSUP)

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# SPARTANBURG HIGH SCHOOL

500 Dupre Drive, Spartanburg, SC 29307 (864) 594-4410 fax (864) 594-6142

I (we) give Spartanburg High School permission to release  
Academic information about my (our) son/daughter,  
\_\_\_\_\_, to authorized  
representatives of college and university athletic programs.  
Such information may include courses taken, grades earned,  
and standardized test scores. This release may be revoked  
at any time upon parent/student request.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature