South Platte Schools

PO Box 457 610 Plum St., Big Springs, Ne 69122
Elem: 308-889-3674 Ext. 1, Fax: 308-889-9691
HS: 308-889-3622 Ext. 2, Fax: 308-889-9645
www.southplatteschools.com

May 31, 2022

To: South Platte Students/Athletes--8 thru 12
From: Nick Brost, A.D.
Re: Physicals & Fall Sports Information

Physicals for the 2022-2023 school year will be required for all participants 7-12th grades. We have enclosed forms that can be used when your student has the exam. However, if your doctor uses a different form, that is acceptable also. In either case, you will need to complete the questionnaire and sign the pre-participation physical evaluation. Sedgwick County Health Center will be doing a group physical day at Julesburg on July 15th. School transportation will leave South Platte School at 8:00 am or you may meet at the clinic at 8:15 am. You will need the pink form filled out as well as all your history pages filled out and SIGNED by your parent!

The Authorization, Medical Eligibility, and History/Physical forms are enclosed. Please sign the forms and take them with you to your physical. Forms must be filled out and signed by parent and student PRIOR to the physical. Make sure you and your parents have signed the forms in all the required places.

NO STUDENT MAY PRACTICE UNTIL A COMPLETED MEDICAL ELIGIBILITY FORM AND ALL CONSENT FORMS ARE RETURNED TO THE COACH OR OFFICE.
All consent forms will be available electronically this year.
The electronic signatures from these forms need to be on file before practice begins!

A copy of the History/Physical Form can be provided to the school for information in case of an emergency. Remember, if you are planning on participating in *any* sport or other extracurricular activity during this next year, you need to get your physical done and it will need to be on file in the office. The Activity Handbook will be provided at the school office and online at www.southplatteschools.com in the upcoming weeks.

Plans are to begin fall sports practice August 8th with a pre-season meeting of all athletes and coaches prior to the first practice.

HS FOOTBALL INFO:
First football practice will be August 8th. Practice details will be determined as time nears.
HS VOLLEYBALL INFO:
Volleyball practice will start August 8th. Schedules will be handed out then.
HS CROSS COUNTRY INFO:
The cross country practice will start August 8th.
JH FB Equipment checkout will be, Thurs Aug. 18th at 1:00 on the stage in the gym.

IMPORTANT INFORMATION

PLEASE READ IMMEDIATELY!!

Because of the Health Information Privacy Act, we are required to have you fill out a release form before your child can be given their athletic physical. The Authorization to Disclose Health Information (pink form) must be filled out completely – signed and dated in the designated areas by a parent or guardian. Please use a separate form for each of your children (do not combine on the forms). Your child must give this form along with the completed physical history form and the clearance form to the staff at the medical clinic on the morning of their physical. **Your child will not be given a physical without these forms - so please make sure they take them!!**

BACK TO SCHOOL NIGHT (K-12)/PARENTS' MEETING

The parents of all South Platte students in grades 7-12 are asked to attend an informational meeting at ***6:00 pm*** on ***Wednesday, August 17th*** in the gymnasium. The purpose of this meeting is to go over important issues that may involve your student/athlete during the 2022-2023 school year. Doors will open at 5:00 to complete and process paperwork, sign up for the adopt a student program, purchase activity passes and deposit money to your lunch account before the meeting (Bring your free and reduced lunch forms with you that you received in the mail. There are no free meals through federal waivers this year, only if you qualify with your income or are directly certified with SNAP, TANIF, or FDPIR.) Students will also be checking out their chromebooks for the upcoming year after the meeting. **First day of classes - August 19th.**

This is a very important meeting and at least one parent from each family is encouraged to attend. Please mark this very important date on your calendar now!

DOOR PRIZE!!

All 7-12 parents present at the meeting will have their names put in a drawing for a free Family Activity Season Pass.

ATHLETIC SCRIMMAGE

The public is invited to attend the high school volleyball and football athletic scrimmages Friday, August 19th.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby request and authorize that Valley Medical Clinic may conduct a sports physical and release the health information of the individual named below, of whom I am a parent or legal guardian:

Name: ______________________________ SSN: ____________________ DOB: ________

Address: ____ Phone: __________________

I authorize the health information of the above-named individual to be disclosed to and used by South Platte School, PO Box 457, 610 Plum St, Big Springs NE 69122, (308) 889-3622 for the purposes of record retention and evaluation with respect to participation and competition in athletic and extracurricular activities sponsored by the school.

The information to be disclosed is that pertaining to the physical conducted on ______________ (date of physical).

I understand that this authorization will expire, without my express revocation, one (1) year from the date of signing. I further understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. That is, I understand that my revocation will not apply to information that has already been released to the school as specified by this authorization.

I understand that authorization for the disclosure of this health information is voluntary and that I can refuse this authorization and that I can refuse to sign this authorization.

I understand that any disclosure of information pursuant to this authorization carries with it the potential for re-disclosure by the school and that such information may not be protected by federal confidentiality rules.

I understand that Valley Medical Clinic will keep this form and retain this copy of this authorization at Valley Medical Clinic at Julesburg CO.

_________________________________ Signature of Parent or Guardian

_________________________ Date

■ 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? (Circle response.)

	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

(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.

____

____

____

____

____

____

____

____

____

____

____

____

____

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: ______________________________

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

■ 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		

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

Name of health care professional (print or type): ______________________ Date: ____________

Address: ______________________________ Phone: ____________

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

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

Parent or Legal Guardian Signature ______________________ *Date* ____________

PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: ______________________ Date of birth: ______________

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	**No**
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

____

____

____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers 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: ______________________

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ______________________________ Date of birth: ______________

☐ 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. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has 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

SHARED EMERGENCY INFORMATION

Allergies: ______________________________

____

____

Medications: ______________________________

____

____

Other information: ______________________________

____

____

Emergency contacts: ______________________________

____

____

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.