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 Incoming 7th Grade Students/Athletes

From: Nick Brost, A.D.

RE: 7th Grade Physical Examination

Dear South Platte Seventh Grade Students and Parents,

This is a reminder that state law requires that all students entering the 7th grade in Nebraska have a physical examination prior to entrance. You may choose any doctor or clinic and all costs are the responsibility of the parent or guardian.

We have enclosed some forms to use 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 and parent's permission forms.

In conjunction with this exam, you will need to have your physician check the immunization records to make sure your child is in compliance with Nebraska Law. If any immunizations are given at the time of the physical, please make sure the school receives a copy of those updates for our records.

NO STUDENT MAY PRACTICE UNTIL A COMPLETED CLEARANCE FORM AND CONSENT FORM IS RETURNED TO THE COACH OR OFFICE.

You may return these forms to either school office anytime during regular business hours this summer. The first day of school is Friday, August 19, 2022 and all forms must be in place by that day. This includes a current copy of your child's immunization records. **A copy of all immunizations needs to be on file in the high school office prior to the first day of classes.**

If there are any questions, please contact our offices at 889-3622 extension 2.

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.

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: _____

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

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: _____

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: _____

_____

_____

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