

# FREE SPORTS PHYSICALS

Sports physicals are required for all in-coming  
Freshmen and Juniors who play sports

South Tahoe Middle and High Schools,  
Whittell Middle and High School, and Pop Warner

## Sports Physicals

July 1-31, 2018

Monday-Saturday

10am - 4pm

Walk-Ins Accepted, No Appointment Needed

**Barton Urgent Care**  
**at Stateline Medical Center**

155 Highway 50

Stateline, NV 89449

**775.589.8900**

**[www.bartonhealth.org](http://www.bartonhealth.org)**

- Forms are available on your school's website or at Stateline Medical Center.
- Minors under age 18 must be accompanied by a parent or guardian.
- Bring completed and signed history and consent forms.
- This evaluation does not replace your student's Annual Preventative Exam.



**Barton**  
*Urgent Care*

**FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM**

<b>HISTORY</b>	DATE OF EXAM: _____
NAME: _____	SEX: _____ AGE: _____ D.O.B.: _____
GRADE: _____ SCHOOL: _____	SPORT(S): _____
ADDRESS: _____	PHONE: _____
PERSONAL PHYSICIAN: _____	
IN CASE OF EMERGENCY, CONTACT - NAME: _____	
RELATIONSHIP: _____	PHONE (H): _____ (W): _____

**EXPLAIN "YES" ANSWERS BELOW.  
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.**

- |   | <i>YES</i> | <i>NO</i> |
|---|------------|-----------|
| 1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?   | _____      | _____     |
| 2. Have you ever been hospitalized overnight?   | _____      | _____     |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?       | _____      | _____     |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?  | _____      | _____     |
| 5. a. Have you passed out or been dizzy during exercise?  | _____      | _____     |
| b. Have you had chest pain (or pressure) with exercise?   | _____      | _____     |
| c. Have you had excessive unexplained shortness of breath or fatigue with exercise?   | _____      | _____     |
| d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?         | _____      | _____     |
| e. Is there any history in your family of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome? | _____      | _____     |
| f. Has a physician denied or restricted your participation in sports for any heart problem?   | _____      | _____     |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?                           | _____      | _____     |
| 7. a. Have you had a head injury or concussion?   | _____      | _____     |
| b. Have you been knocked out, become unconscious, or lost your memory?  | _____      | _____     |
| c. Have you had a seizure?  | _____      | _____     |
| d. Do you have frequent or severe headaches?  | _____      | _____     |
| e. Have you had numbness or tingling in your arms, hands, legs, or feet?  | _____      | _____     |
| 8. Have you become ill from exercising in the heat?   | _____      | _____     |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?  | _____      | _____     |

*Over >*

- |  | YES   | NO    |
|--|-------|-------|
| 10. a. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | _____ | _____ |
| b. Are you missing an eye, kidney, testicle or ovary?  | _____ | _____ |
| 11. a. Have you had any problems with your eyes or vision?   | _____ | _____ |
| b. Do you wear glasses, contacts, or protective eyewear?   | _____ | _____ |
| 12. a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?  | _____ | _____ |
| b. If yes, check appropriate item and explain below.   |       |       |

- |                 |                 |                 |
|-----------------|-----------------|-----------------|
| _____ Head      | _____ Elbow     | _____ Hip       |
| _____ Neck      | _____ Forearm   | _____ Thigh     |
| _____ Back      | _____ Wrist     | _____ Knee      |
| _____ Chest     | _____ Hand      | _____ Shin/Calf |
| _____ Shoulder  | _____ Finger(s) | _____ Ankle     |
| _____ Upper Arm | _____ Foot      | _____ Toe(s)    |

13. Are you actively trying to gain or lose weight? \_\_\_\_\_
14. Would you like to talk to someone about stress, anger, depression or other issues? \_\_\_\_\_
15. Record the dates of your most recent immunizations (shots) for:
- Tetanus \_\_\_\_\_ Measles \_\_\_\_\_
- Hepatitis B \_\_\_\_\_ Chickenpox \_\_\_\_\_

**FEMALES ONLY**

16. When was your first menstrual period? \_\_\_\_\_
- When was your most recent menstrual period? \_\_\_\_\_
- How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
- How many periods have you had in the last year? \_\_\_\_\_
- What was the longest time between periods in the last year? \_\_\_\_\_

**EXPLAIN "YES" ANSWERS HERE:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_ Phone: \_\_\_\_\_

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

Street City State Zip Code

I, \_\_\_\_\_ hereby certify that I am a licensed \_\_\_\_\_, and have reviewed the information in this FORM B prior to conducting a physical examination for the assigned student.

Signature of Health Practitioner License Number Office Phone Number Date

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

Signature of Athlete Signature of Parent/Guardian Date

**FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.**

**NIAA PRE-PARTICIPATION PHYSICAL EVALUATION**

**(Physical to be completed during an athletes first and third year of participation)**

<b>PHYSICAL EXAMINATION</b>		DATE OF EXAMINATION: _____
NAME: _____		DATE OF BIRTH: _____
HEIGHT: _____	WEIGHT: _____	% BODY FAT (optional): _____ PULSE: _____ BP: ____/____ (____/____, ____/____)
VISION: R 20/ _____	L 20/ _____	CORRECTED: Y / N PUPILS: Equal _____ Unequal _____

<u>MEDICAL</u>	NORMAL /ABSENT	ABNORMAL FINDINGS	EXPLAIN	INITIALS
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
<u>CARDIOVASCULAR</u>				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
<u>MUSCULOSKELETAL</u>				
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				
Stigmata of Marfan's Syndrome				

**CLEARED** after completing evaluation/rehabilitation for: \_\_\_\_\_

**NOT CLEARED FOR:** \_\_\_\_\_ **REASON:** \_\_\_\_\_

**Recommendations:** \_\_\_\_\_

**Name of physician (print/type):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  

Street
City
State
Zip Code

I, \_\_\_\_\_ hereby certify that I am a licensed \_\_\_\_\_, qualified to perform NIAA Pre-Participation Evaluations, and that on the date set forth below I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NIAA sanctioned sports.

Signature of Health Practitioner	License Number	Office Phone Number	Date
----------------------------------	----------------	---------------------	------

Revised 5-2010; June 2012

**FORM E -- NIAA HEALTH QUESTIONNAIRE / INTERIM FORM**

**This evaluation should be completed only if you have a physical on file from last year.**

**This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. A positive response to any of the following questions requires a medical examination before activity can resume.**

NAME: _____	AGE: _____	GRADE: _____	DATE: _____
ADDRESS: _____		PHONE: _____	
SPORT(S): _____			
DATE OF LAST COMPLETE SPORTS PHYSICAL (PPE): _____		WHERE: _____	

**SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):**

	<i>YES</i>	<i>NO</i>
1. Have you had a medical illness or injury that required you to visit a physician and miss FIVE or more consecutive days of school or sports?	_____	_____
2. Have you been hospitalized overnight	_____	_____
3. a. Have you passed out or been dizzy with exercise?	_____	_____
b. Have you had chest pain (or pressure) with exercise?	_____	_____
c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
d. Has someone in your family died, or developed serious problems, due to heart disease who was younger than 50 years old?	_____	_____
e. Have you learned of anyone in your family who has any history of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
4. a. Have you had a head injury or concussion?	_____	_____
b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
c. Have you had a seizure?	_____	_____
d. Have you developed frequent or severe headaches?	_____	_____
e. Have you developed numbness or tingling in your arms, hands, legs, or feet?	_____	_____
5. Have you become sick from exercising in the heat?	_____	_____
6. Have you developed a cough, wheeze, or have trouble breathing during or after activity?	_____	_____
7. Have you started requiring any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____

*Over >*

- |   | YES   | NO    |
|---|-------|-------|
| 8. Have you had any problems with your eyes or vision, other than requiring glasses or contacts?  | _____ | _____ |
| 9. Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you? | _____ | _____ |

*If yes, check appropriate item below.*

- |                 |                 |                 |
|-----------------|-----------------|-----------------|
| _____ Head      | _____ Elbow     | _____ Hip       |
| _____ Neck      | _____ Forearm   | _____ Thigh     |
| _____ Back      | _____ Wrist     | _____ Knee      |
| _____ Chest     | _____ Hand      | _____ Shin/Calf |
| _____ Shoulder  | _____ Finger(s) | _____ Ankle     |
| _____ Upper Arm | _____ Foot      | _____ Toe(s)    |

10. Would you like to talk to a physician about your weight, about stress, anger, depression or any other issues?

\_\_\_\_\_

**FEMALES ONLY**

11. If you have been having periods for one year or longer, have they become less regular?

\_\_\_\_\_

**IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE SEE YOUR FAMILY PHYSICIAN FOR A COMPLETE PHYSICAL.**

---

12. Have you developed any new allergies (for example, to pollen, medicine, food, or stinging insects)? If so, please list:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
Signature of Athlete

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

\_\_\_\_\_  
Date