



Date: 3/18/2022
Schools: Jonesboro, Nettleton, Valley View, Westside, Brookland, Bay, Riverside
Attention: Coaches and Parents

St. Bernards Sports Medicine is proud to provide this year's physicals for our covered schools. We are excited to announce the continued partnership of St. Bernards Sports Medicine and St. Bernards Medical Group in an effort to provide the most comprehensive athletic physical possible. The physicals will be held on SUNDAY – APRIL 10th at the First National Bank Arena on the A-State campus. Athletes and their parents MUST enter through the YELLOW ENTRANCE. You will proceed to the registration tables. Please note that junior high is for those students entering 7th-8th grade this fall, and senior high is for those students entering 9th – 12th grade. Please read the instructions below to help make this event a success.

SCHOOL TIMES (suggested for traffic flow and wait times)

11:00 a.m. - Brookland	1:30 p.m. – Jonesboro High School
11:30 a.m. - Nettleton Jr. High	2:00 p.m. - Riverside
11:45 a.m. - Nettleton Sr. High	2:15 p.m. - Valley View Jr. High
12:00 p.m. - Bay	2:30 p.m. - Valley View Sr. High
12:30 p.m. - Annie Camp, Jonesboro	3:00 p.m. – Westside
1:00 p.m. - MacArthur, Jonesboro	

IMPORTANT

1. Parents – You must complete the following forms prior to your child attending the April 10th evaluation:
 - a. Consent to Participate (St. Bernards requirement)
 - b. HIPAA Authorization (St. Bernards requirement)
 - c. History Form pages 1-2 (AAA and school requirement)
 - d. Physical Examination Form – name and date of birth ONLY at the top
2. Wear appropriate clothing – wind pants or gym shorts. No skirts or tight blue jeans. Sport bra recommended for females under their shirts.
3. Physicals are for all athletes entering Grades 7-12 during the 2022-2023 school year. This includes current 6th graders planning to play school sports next season.
4. Coaches are encouraged to be present to help with crowd control.
5. **NO MAKE UP DATE.**

ELECTROCARDIOGRAM (EKG)

In collaboration with Drs. Devi Nair, David Vance and Raphael Ngengwe, Electrophysiologists with St. Bernards Heart & Vascular here in Jonesboro, St. Bernards Sports Medicine will be providing FREE EKG screenings to our SENIOR HIGH (those students entering 9th – 12th grades) athletes. This screening examines the heart rhythms and can identify abnormalities that could be life-threatening. It is important to note that EKGs are not mandatory for athletic participation; however, we highly recommend taking advantage of this opportunity.

I would like to thank you in advance for your cooperation in this event. We are proud to serve our athletic community and look forward to assisting you in the future. Thank you and have a great year!

Sincerely,

Andy Shatley, PT
Director
St. Bernards Sports Medicine

CONSENT TO PARTICIPATE IN PRE-PARTICIPATION PHYSICAL EVALUATIONS

I, the parent or legal guardian of Student or Student (if over 18 years of age), hereby authorize St. Bernard's Hospital, Inc. dba St. Bernards Medical Center, Cardiology Associates of Jonesboro, Inc. dba St. Bernards Heart & Vascular, Therapy Providers of Arkansas, LLC, Student's athletic trainer and any providers or provider's assistants at the 2022 St. Bernards Health & Fitness Expo to perform pre-participation physical evaluations ("Evaluations"), including physical screening exams, on Student. I understand Evaluations are not comprehensive exams. I understand Evaluations are not intended to provide treatment or create a physician-patient relationship.

I understand that the Evaluations cannot detect all health problems or prevent injury from athletic participation. I understand that if a follow-up evaluation is recommended, it is my responsibility to seek care from the appropriate provider.

I have completed and reviewed the Pre-Participation Physical Evaluation- History Form ("History Form"). I represent that my responses on the History Form are complete, true and correct to the best of my knowledge, information and belief.

Student Name: _____

Student Signature: _____

Date: _____

IF STUDENT IS A MINOR, A PARENT OR GUARDIAN MUST EXECUTE THE CONSENT

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

STUDENT HIPAA AUTHORIZATION

By my signature, I authorize use or disclosure of protected health information about the Student as described below.

1. The following specific person/class of persons/facility is authorized to use or disclose information about the Student: *St. Bernard's Hospital, Inc. dba St. Bernards Medical Center, Cardiology Associates of Jonesboro, Inc. dba St. Bernards Heart & Vascular, the Student's athletic trainer and any providers performing physical exams on the Student at St. Bernards Health & Fitness Expo(s)*

2. The following person (or class of persons) *may receive disclosure* of protected health information about the Student: *Any and all coaches, athletic trainers, athletic directors, health care providers, medical staff and teachers and others as necessary to evaluate or communicate the Student's health status and ability to participate in athletic events. This authorization also authorizes the persons listed in Sections 1 and 2 to upload and maintain the Student's information to SportsWare OnLine. The authorization also allows persons listed in Section 1 to disclose the Student's protected health information to his or her parent (or adult standing in loco parentis or guardian prior to Student obtaining majority) as necessary to coordinate the student's care or participation in athletic events.*

3. The specific information that should be disclosed is (psychotherapy notes are excluded): *Any and all protected health information necessary to evaluate or communicate the Student's health status and ability to participate in athletic events, including all information that is generated as a result of Student's participation in physical exams at St. Bernards Health & Fitness Expo and information maintained on SportsWare OnLine. The information released may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV). It may also include information about mental or behavioral health services or treatment for alcohol or drug abuse.*

4. The information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. The authorization may be revoked by notifying Daya Shipman, 225 E. Washington, Jonesboro, AR 72401 (870-207-4422), in writing of your desire to revoke it. However, any action already taken in reliance on this authorization cannot be reversed, and revocation will not affect those actions. The medical provider to whom this authorization is furnished may not condition its treatment of the Student on whether or not the authorization is executed.

6. The purpose for/intended use of the information is: *to allow the Student's athletic trainer, athletic director coaches, providers and others to evaluate and communicate the Student's health status and ability to participate in athletic events.*

7. This authorization expires: *upon the Student's graduation or withdraw from high school.*

A copy of this completed, signed and dated form must be given to the individual or other signator.

Student Name: _____ Date of Birth: _____

Signature of Student (if student is over 18): _____

Signature of Personal Representative (if Student is not over 18): _____

Relationship (ex. Parent or Legal Guardian): _____

Date: _____

IF STUDENT IS A MINOR, A PARENT OR LEGAL GUARDIAN MUST EXECUTE THE AUTHORIZATION.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM- Page 1



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: _____

Have you had COVID-19? ☐ Yes ☐ No

Have you been immunized for COVID-19? ☐ Yes ☐ No

If yes, you have had: ☐ One shot ☐ Two shots

List past and current medical conditions:

Have you ever had surgery? If yes, list all past surgical procedures:

Medicines and supplements- List all current medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, list all of your allergies (ie medicines, pollens, food, stinging insects):

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?				

HISTORY FORM- Page 2



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 <i>Staphylococcus aureus</i> (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.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

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: _____

EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

FORMULARIO DE HISTORIAL CLÍNICO- Número de página- 1



Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer: _____

¿Ha tenido COVID-19?: ☐ Sí ☐ No

¿Ha recibido la vacuna contra el COVID-19?: ☐ Sí ☐ No

Si la respuesta es sí, usted recibió: ☐ Una dosis ☐ Dos dosis

Mencione los padecimientos médicos pasados y actuales que haya tenido:

¿Alguna vez se le practicó una cirugía? Si la respuesta es sí, haga una lista de todas sus cirugías previas:

Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume:

¿Sufre de algún tipo de alergia? Haga una lista de todas sus alergias (medicamentos, alimentos, picaduras de insectos):

PREGUNTAS GENERALES (Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).		
	Sí	No
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR		
	Sí	No
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (CONTINUACIÓN)		
	Sí	No
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA		Sí	No
11. ¿Algún miembro de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicable)?			
12. ¿Algún miembro de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?			
13. ¿Algún miembro de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?			
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES		Sí	No
14. ¿Algún miembro de su familia sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?			
15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?			
PREGUNTAS SOBRE CONDICIONES MÉDICAS		Sí	No
16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?			
17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?			
18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?			
19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?			

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)		Sí	No
20. ¿Algún miembro de su familia sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?			
21. ¿Algún miembro de su familia sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?			
22. ¿Algún miembro de su familia se enfermó al realizar ejercicio cuando hacía calor?			
23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?			
24. ¿Algún miembro de su familia tuvo o tiene algún problema con sus ojos o su visión?			
25. ¿Le preocupa su peso?			
26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?			
27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?			
28. ¿Algún miembro de su familia sufrió un desorden alimenticio?			
ÚNICAMENTE MUJERES		Sí	No
29. ¿Ha tenido al menos un periodo menstrual?			
30. ¿A los cuántos años tuvo su primer periodo menstrual?			
31. ¿Cuándo fue su periodo menstrual más reciente?			
32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?			

Proporcione una explicación aquí para las preguntas en las que contestó "Sí".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM



Name: _____ Date of birth: _____

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* Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), methicillin-resistant <i>Staphylococcus aureus</i> (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

† Cleared for all sports without restriction

† Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

† Not cleared

† Pending further evaluation

† For any sports

† For certain sports _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of provider: _____ Date of exam: _____

Address: _____ Phone: _____

Signature of physician, APN, PA: _____