# Coconut Creek High School Athletics

Prior to any physical activity conducted on campus each student athlete must have the following completed:

1. Updated physical
2. Insurance card
3. Register my athlete account

Once the athlete has completed an updated physical it is mandatory that they register at the following website: www.registermyathlete.com

Parents, please create a parent account followed by registering your child as an athlete by searching for Coconut Creek High School, registering for the applicable sports, and filing out all the necessary documents.

**Please upload your child's physical and their insurance card to this portal and wait for approval**. Once the electronic documents, final e-signature, physical documents, and fundraisers tabs are completed-your child is now eligible to tryout for a sport.

**If your child does not have health insurance, please visit www.schoolinsuranceofflorida.com where medical coverage for the season can be purchased.

**Should you have any questions please reach out to Ms. A, the Athletic Trainer at 754-322-0423 or e-mail aline.valiengo@browardschools.com

**PREPARTICIPATION PHYSICAL EVALUATION** (Page 1 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*
*This form is valid for 365 calendar days from the date signed below.*

**EL2**

**Revised 3/23**

## MEDICAL HISTORY FORM

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___ /___ /_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

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

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

_____

**Patient Health Questionaire version 4 (PHQ-4)**

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

| | Not at all | Several days | Over half of the days | Nearly everyday |
|---|---|---|---|---|
| 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 |

| | **GENERAL QUESTIONS**<br>Explain "Yes" answers at the end of this form.<br>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 illnesses? | | |
| | **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? | | |

| | **HEART HEALTH QUESTIONS ABOUT YOU** *(continued)* | **Yes** | **No** |
|---|---|---|---|
| 8 | Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)? | | |
| 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? (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 catecholaminerigc polymorphic ventricular tachycardia (CPVT)? | | |
| 13 | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |

**This form is not considered valid unless all sections are complete.**

**PREPARTICIPATION PHYSICAL EVALUATION** (Page 2 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*
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**EL2**

**Revised 3/23**

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

| | BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|---|
| 14 | Have you ever had a stress fracture? | | |
| 15 | Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 16 | Do you have a bone, muscle, ligament, or joint injury that currently bothers you? | | |

| | MEDICAL QUESTIONS | Yes | No |
|---|---|---|---|
| 17 | Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma? | | |
| 18 | Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? | | |
| 19 | Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 20 | Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)? | | |
| 21 | Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 22 | 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? | | |
| 23 | Have you ever become ill while exercising in the heat? | | |
| 24 | Do you or does someone in your family have sickle cell trait or disease? | | |
| 25 | Have you ever had or do you have any problems with your eyes or vision? | | |

| | MEDICAL QUESTIONS *(continued)* | Yes | No |
|---|---|---|---|
| 26 | Do you worry about your weight? | | |
| 27 | Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 28 | Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 29 | Have you ever had an eating disorder? | | |

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

**This form is not considered valid unless all sections are complete.**

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

*This medical history form should be retained by the healthcare provider and/or parent.*
*This form is valid for 365 calendar days from the date signed below.*

**EL2**
**Revised 3/23**

## PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

**PHYSICIAN REMINDERS:**
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? | • 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? | |

☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

**EXAMINATION**

**Height:** **Weight:**

**BP:** / ( / ) **Pulse:** **Vision:** R 20/ L 20/ **Corrected:** Yes No

| **MEDICAL - healthcare professional shall initial each assessment** | **NORMAL** | **ABNORMAL FINDINGS** |
|---|---|---|
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, Ears, Nose, and Throat<br>• Pupils equal<br>• Hearing | | |
| Lymph Nodes | | |
| Heart<br>• Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis | | |
| Neurological | | |
| **MUSCULOSKELETAL - healthcare professional shall initial each assessment** | **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<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

**This form is not considered valid unless all sections are complete.**

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

*SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL*

*This form is valid for 365 calendar days from the date signed below.*

**EL2**

**Revised 3/23**

## MEDICAL ELIGIBILITY FORM

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___ /___ /_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

**SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent**

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other

Explain: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian:_____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

**This form is not considered valid unless all sections are complete.**

**PREPARTICIPATION PHYSICAL EVALUATION** (Supplement)

*SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL*

*This form is valid for 365 calendar days from the date signed below.*

**EL2**

**Revised 3/23**

*This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.*

## MEDICAL ELIGIBILITY FORM - Referred Provider Form

**Student Information** (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___ /___ /_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

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Referred for: _____ Diagnosis: _____

*I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:*

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

_____

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Name of Healthcare Professional (print or type): _____ Date: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*