OAKS CHRISTIAN SCHOOL

OCS PHYSICAL and ONLINE ATHLETIC FORM

-- PARTICIPANTS IN EVERY SPORT MUST COMPLETE A NEW SPORTS PACKET EVERY ACADEMIC YEAR--

The student is not eligible to participate in try outs, practices, weight lifting or competitions until…
(1) the athlete is registered at **AthleticClearance.com**,
(2) all Online Athletic Forms are completed and submitted on AthleticClearance.com, and
(3) the entire OCS Physical is completed and signed by an MD or DO and uploaded to **AthleticClearance.com**.

The **OCS PHYSICAL** includes the following forms:

1. Cardiac Screening Questionnaire
2. Immunization Form
3. History Form
4. Physical Examination Form
5. Clearance Form

All FIVE (5) forms (5 pages) must be completed in full and uploaded to AthleticClearance.com.
The Pre-participation Physical Examination (PPE) is the responsibility of the participating family.

"The PPE Form must be completed in its entirety and the examination conducted by a licensed physician who is qualified to properly evaluate each of the items required by the PPE Form. Typically a licensed sports medicine doctor or an internist or a family general practitioner should be able to make these evaluations. The licensed physician conducting the examination and completing the PPE Form shall not be related to the student athlete."
(Physicals signed by chiropractor, nurse practitioners, physician's assistant will not be accepted)

- A new physical must be acquired after May 1, 2019 for the **2019-20** school year.
- Students who might participate in a sport during the **2019-20** school year **must** have a SPORTS PHYSICAL on file **before participation** in tryouts, practice, weight room or contests.

The **ONLINE ATHLETIC FORMS** on AthleticClearance.com include the following forms:

1. Parent / Athlete Commitment
2. Multisport Athlete Commitment
3. Parent's Permission Form
4. Athlete's Agreement
5. Assumption of Risk
6. Athletic Policy Against Hazing Agreement
7. Use of Steroid Policy Agreement
8. CIF State Concussion Information / Waiver
9. CIF State Sudden Cardiac Awareness Information / Wavier
10. CIF Southern Section Athlete's Code of Ethics Agreement
11. Parent Code of Conduct Agreement
12. Heat Illness Awareness Waiver

All questions may be addressed to the Athletic Training Staff at 818. 575.9241.

Mr. Jan Hethcock
Athletic Director

MAKE KEEP COPIES OF YOUR PHYSICAL FOR YOUR RECORDS!!!

Oaks Christian School
Cardiac Screening Questionnaire

Student's Name (Print): _____ **Date of Birth:** _____

Heart conditions are affected by a number of variables. Answering honestly will help doctors accurately assess your cardiac health.

What is the student's race/ethnicity (Please circle)? **African-American** **Caucasian** **Other**

Please circle your responses (If unknown, leave blank)

1. Do you participate in sports? If yes, which one(s)?_____ YES NO
2. Have you ever been told to limit your participation in sports? YES NO
3. Have you ever experienced chest pain or discomfort with exercise? YES NO
4. Have you ever had excessive shortness of breath or fatigue with exercise? YES NO
5. Have you ever passed out or nearly passed out? YES NO
6. Have you ever been told you have a heart murmur? YES NO
7. Have you had high blood pressure? YES NO
8. Does anyone in your family have hypertrophic or dilated cardiomyopathy, Long QT, Marfan syndrome, or any other heart arrhythmia problems? YES NO
9. Has anyone in your family under the age of 50 died suddenly or unexpectedly from heart disease? YES NO
10. Has anyone in your family under the age of 50 been disabled from heart disease? YES NO
11. Have you had a physician order a heart test for you? YES NO
12. Are you currently taking any prescription medication? YES NO
    If yes, what?_____
13. Have you ever used performance enhancing drugs and/or supplements? YES NO
    If yes, please list _____
14. Do you drink energy drinks? If Yes, how many per day? _____ YES NO

Additional comments: _____

FOR PHYSICIAN USE ONLY:

1. Femoral pulses – Aortic Coarctation YES NO
2. Heart Murmur YES NO
3. Marfan syndrome Physical Stigmata YES NO
4. Based on the answers above is an EKG necessary? YES NO Echo necessary? YES NO

Blood Pressure _____ **Pulse** _____ **EKG (result)**_____ **Echo (result)**_____

Physician Signature: _____ **Date/Time**: _____

OAKS CHRISTIAN SCHOOL
IMMUNIZATION FORM

Immunization and OCS Physical: Required for all 9th grade & new 10th, 11th, & 12th grade students
OCS Physical: Required annually for ALL participants in OCS Sports, P.E., Dance

OCS Physical and Immunization Form MUST be completed by an MD or DO only!!
Immunization Form must be submitted to Health Office by August 1, 2018

Student's Name_____ Grade in August_____

Date of Birth _____ **Height** _____ **Weight** _____ Pulse _____ B/P_____

IMMUNIZATIONS (As required by state law) MUST be completed by MD office for new students:

VACCINE	1st dose	2nd dose	3rd dose	4th dose	5th dose
POLIO (OPV or IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/DT/Td	/ /	/ /	/ /	/ /	/ /
Tdap Booster 7th-12th	/ /				
MMR	/ /	/ /			
HIB MENINGITIS	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA	/ /	/ /			
HEPATITIS A	/ /	/ /			

T.B. SKIN TEST (Required if NEW to California Schools)
PPD-MANTOUX TEST Date Given _____ Date Read _____ Results _____
CHEST X-RAY (necessary if skin test positive) Film Date _____ Results _____
This person is free of communicable tuberculosis: Yes _____ No_____

Last Vision Screening **(Required)** Date _____ Right Eye _____ Left Eye _____
With Correction: Right Eye _____ Left Eye _____

Last Hearing Screening **(Recommended)** Date _____ Right Ear _____ Left Ear _____

Posture _____ Scoliosis Screening Date _____ **(Required)**

MEDICATIONS (Presently taking):

_____

_____

MEDICAL CONDITIONS INCLUDING ALLERGIES:

_____ _____

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

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, 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 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 (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____/____ (____/____) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ 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. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ 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. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____