

Attention: Irene-Wakonda Student Athletes and Parents

Pioneer Memorial Hospital & Health Services will be offering medical services for athletic physical examinations. Two options are available:

Option 1 – To be done at the SCHOOL

- When and Where: **Monday, August 2nd, 1pm-3-pm, IW High School**
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures.** Forms are available through your school.
- **\$30** is due when you arrive on this date.

Option 2 – To be done at the CLINIC

- Please make an appointment with the clinic:

| | |
|-----------------------------------|-----------------|
| Centerville Medical Clinic | 563-2411 |
| Parker Medical Clinic | 297-3888 |
| Viborg Medical Clinic | 326-5201 |
- **What to schedule? Sports physical or well-child visit?**
 - An annual well-child visit includes a comprehensive look at the overall health & well-being, with both physical and mental health concerns addressed. Sports physicals focus particularly on physical growth, cardiovascular health, musculoskeletal health, and risk reduction.
 - ***A well-child visit can double as a sports physical, but a sports physical can't be considered a well-child visit.***
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures.** Forms are available through your school.
- Payment is due at the time of service. Pricing if done in the clinic:
 - **Well-child visit:** The well-child visit will be filed with your insurance company at the standard price. Most insurance companies fully cover well-child visits once a year; this can be confirmed by calling the phone number on your insurance card.

Please feel free to contact the clinics listed above with questions.

South Dakota High School Activities Association



Pre-Participation Form Packet

2021-22 School Year

Last Updated: March 26, 2021 by Krogstrand

Patient name _____
 Legal name Last First Middle initial Soc. Sec. #

Alternative names/maiden/nicknames _____ Hispanic/Latino Ethnical Background Yes No

Sex Male Female Birth date _____ Race _____

Marital status M S Divorce Widowed Separated Email _____

Address _____
 Street PO Box City State Zip

Home phone () Work phone () Cell phone ()

Employer Occupation

Employer address _____
 Street PO Box City State Zip

Spouse's name Birth date Soc. Sec. #

Employer Occupation

Work phone () Cell phone ()

Employer address _____
 Street PO Box City State Zip

RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)

Mother's name Birth date Soc. Sec. #

Address _____
 Street PO Box City State Zip Home phone ()

Employer Occupation Cell phone ()

Employer address _____
 Street PO Box City State Zip

Father's name Birth date Soc. Sec. #

Address _____
 Street PO Box City State Zip Home phone ()

Employer Occupation Cell phone ()

Employer address _____
 Street PO Box City State Zip

EMERGENCY CONTACT

Name Relationship to patient

Address _____
 Street PO Box City State Zip

Home phone () Work phone () Cell phone ()



PATIENT INFORMATION
 VMC 2005
 Revised 12/4/2019

NAME _____
 DOB _____



HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

Name: _____

Date of Birth: _____

Date of Exam: _____

Sports: _____

| | |
|--|--|
| List all past and current medical conditions: | |
| Have you ever had surgery? If Yes, list all procedures: | |
| List all prescriptions, over-the-counter meds or supplements you currently take: | |
| Do you have any allergies? If Yes, Please list them here: | |

Over the last two weeks, how often have you been bothered by 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 in pleasure or doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR" & EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:

| GENERAL QUESTIONS | | | Yes | No | BONE AND JOINT QUESTIONS, CONTINUED: | | | Yes | No |
|---|--|--|-----|----|--------------------------------------|---|--|-----|----|
| 1. | Do you have any concerns you'd like to discuss with your provider? | | | | 15. | Do you have a bone, muscle, ligament or joint injury that bothers you? | | | |
| 2. | Has a provider ever denied or restricted your participation in sports for any reason? | | | | MEDICAL QUESTIONS | | | Yes | No |
| 3. | Do you have any ongoing medical issues or recent illnesses? | | | | 16. | Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |
| HEART HEALTH QUESTIONS ABOUT YOU | | | Yes | No | 17. | Are you missing a kidney, an eye, a testicle, your spleen or any other organ? | | | |
| 4. | Have you ever passed out or nearly passed out during or after exercise? | | | | 18. | Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | | |
| 5. | Have you ever had discomfort, pain, tightness or pressure in your chest during exercise? | | | | 19. | Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA? | | | |
| 6. | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | | | 20. | Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems? | | | |
| 7. | Has a doctor ever told you that you have any heart problems? | | | | 21. | Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | | |
| 8. | Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography) | | | | 22. | Have you ever become ill while exercising in the heat? | | | |
| 9. | Do you get light-headed or feel shorter of breath than your friends during exercise? | | | | 23. | Do you or does someone in your family have sickle cell trait or disease? | | | |
| 10. | Have you ever had a seizure? | | | | 24. | Have you ever had, or do you have any problems with your eyes or vision? | | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | | | Yes | No | 25. | Do you worry about your weight? | | | |
| 11. | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash) | | | | 26. | Are you trying to, or has anyone recommended that you gain or lose weight? | | | |
| 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)? | | | | 27. | Are you on a special diet, or do you avoid certain types of foods or food groups? | | | |
| 13. | Has anyone in your family had a pacemaker or implanted defibrillator before age 35? | | | | 28. | Have you ever had an eating disorder? | | | |
| BONE AND JOINT QUESTIONS | | | Yes | No | 29. | Have you ever had COVID-19? | | | |
| 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 a game? | | | | FEMALES ONLY | | | Yes | No |
| | | | | | 30. | Have you ever had a menstrual period? | | | |
| | | | | | 31. | How old were you when you had your first period? | | | |
| | | | | | 32. | When was your most recent period? | | | |
| | | | | | 33. | How many periods have you had in the past 12 months? | | | |

CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

Athlete Name: _____ Date of Birth: _____
 Date of Exam: _____ Annual/Biennial/Triennial: _____

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?
 - Have you ever tried cigarettes, e-cigarettes, vaping, chewing tobacco, snuff or dip?
 - Over the past 30 days, have you used 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 seatbelt or helmet?
- Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)**

| EXAMINATION | | |
|-------------|--------------------------|-------------|
| Height: | Weight: | BP: |
| Pulse: | Vision: R 20/ L 20/ | Corrected?: |

| MEDICAL | Normal | Abnormal Findings |
|--|--------|-------------------|
| Appearance | | |
| Head/Mouth | | |
| Eyes, ears, nose and throat - Pupils equal & Hearing | | |
| Lymph Nodes | | |
| Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation | | |
| Lungs | | |
| Abdomen - Liver/Spleen, masses | | |
| Skin - HSV, Lesions, Staphy, MRSA, etc | | |
| Neurological | | |
| MUSCULOSKELETAL | Normal | Abnormal Findings |
| Neck | | |
| Back | | |
| Shoulder & Arm | | |
| Elbow & Forearm | | |
| Wrist, Hand and Fingers | | |
| Hip & Thigh | | |
| Knee | | |
| Leg & Ankle | | |
| Foot & Toes | | |
| Functional | | |
| • Double-leg squat test, single-leg squat test, box drop or step drop test | | |

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination

Sports Participation Recommended for (Mark One):

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____
- Medically eligible for certain sports (list here): _____
- Not medically eligible pending further evaluation _____
- Not medically eligible for any sports _____

Name of Examiner: _____
 Signature of Examiner: _____
 Date of Exam: _____

Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.

Form adapted with permission © American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2019

SDHSAA CONSENT FOR PARTICIPATION IN ACTIVITIES

Student Name: _____

Date of Birth: _____

School Year: 2021-22 School Year

Place of Birth: _____

Name of High School: _____

Grade: _____

The parent and student, by signing this form, hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that:
 - (a) By this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation;
 - (b) Participation in any athletic activity may involve injury of some type;
 - (c) The severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death;
 - (d) Even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility; and;
 - (e) By signing this form, I/we give our consent for the listed student to compete in SDHSAA approved athletics for the school year as listed on this form. Further, I/we give our permission for our child to participate in organized high school athletics, realizing that such activity involves the potential for injury and harm which exists as an inherent element in all sports.

3. Understand, consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Understand, consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. If I/we do not wish to have any or all such information disclosed, I/we must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.

Signature of Parent

Date

Signature of Student

Date

SDHSAA CONSENT FOR MEDICAL RELEASE FORM (HIPAA)

Student Name: _____ Grade: _____ Date of Birth: _____

I/We the undersigned do hereby:

1. Authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information for the purposes of evaluating, observing, diagnosing and creating treatment plans for injuries that occur during the time period covered by this form, or, from pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the medical care of this student.
3. This information for which I/we are authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2022.
6. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Schools, School districts and school personnel are to uphold the bounds of FERPA. As such, disclosure and re-disclosure by schools or school employees must be done in compliance with FERPA guidelines.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

Signature of Parent

Date

Signature of Student (if over 18 or turning 18 before July 1, 2022)

Date

SDHSAA CONCUSSION FACT SHEET FOR STUDENTS

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
 - The right equipment for the game, position, or activity
 - Worn correctly and the correct size and fit
 - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

IT IS BETTER TO MISS ONE GAME THAN A WHOLE SEASON – SEE SOMETHING – SAY SOMETHING!!!

Student's Name (Please Print)

Date

Signature of Student

Date

Parent's Signature

Date

SDHSAA CONCUSSION FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

| Signs Observed By Parents or Guardians | Symptoms Reported by Athlete |
|--|---|
| <ul style="list-style-type: none"> • Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes • Can't recall events prior to hit or fall • Can't recall events after hit or fall | <ul style="list-style-type: none"> • Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down" |

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your child has a concussion?

1. **Keep your child out of play.** If your child has a concussion, her/his brain needs time to heal. Don't let your child return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your child is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
3. **Teach your child that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your child convince you that s/he's "just fine".
4. **Tell all of your child's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your child has ever had a concussion. Your child may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your child's coaches, school nurse, and teachers. If needed, they can help adjust your child's school activities during her/his recovery.

Parent's Name

Date

Signature of Parent

Date

Student's Name