BAXTER HEALTH

Dear Parent,

It is hard to believe, but it is time for our annual pre participation physicals. We will be offering a free physical for our area student athletes. The physicals will be given at the BRMC Physical Therapy Department. The dates selected for the physicals are: **Monday, April 20th for the girls and Wednesday, April 22nd for the boys.** The physicals will start at 6:00 p.m. We will be following the schedule below. Please do not attempt to enter the physicals before your allotted time. You will not be allowed to enter until your age group's appointment time. To decrease time spent in line, please refer to the schedule below:

7th Grade (next year):	**6:00 p.m.**	
8th Grade (next year):	**6:20 p.m.**	
9th Grade (next year):	**6:40 p.m.**	**(The same schedule will be**
10th Grade (next year):	**7:00 p.m.**	**followed on both nights.)**
11th Grade (next year):	**7:20 p.m.**	
12th Grade (next year):	**7:40 p.m.**	
College Bound:	**8:00 p.m.**	

1) **ALL MINOR CHILDREN MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN!!!!**
2) **We ask that you please go in the room with your child or stand outside the door of the exam room they are in. Otherwise, you will clog up the hallway & walk through areas.**
3) **Please have PHYSICAL EXAMINATION FORMS completed prior to arrival.**

We encourage each area athlete to obtain a sports physical on these nights. If the athlete does not receive the free physical at Baxter Health, then it is the responsibility of his/her parents to make sure a physical is completed before joining any sports teams in the fall. This will be the only opportunity to receive a free physical; there will be no make-ups. Please remember this physical meets state requirements, your general physician may give you a more thorough physical.

Sincerely,

Callie Hendricks

Callie Hendricks, ATC, LAT, MSE
Baxter Health

BAXTER HEALTH

PHYSICAL EXAMINATION RELEASE
For Area Schools

_____ **Public School**

Student's Name _____ Home Phone # _____
(Please Print)

Address/City/Zip _____

Parent or Guardian's Business Phone # _____

Your Parent or Guardian must sign for you to be examined.

We, the undersigned parent or guardian, acknowledge that this is not a comprehensive physical examination and is done solely to provide general information regarding the student's ability to physically participate in school extracurricular activities.

We, the undersigned, acknowledge the importance of the medical history in helping the physician determine the student's ability to physically participate in school extracurricular activities.

We, the undersigned, acknowledge that Baxter Regional Medical Center will be providing the students completed physical in paper and digital format to their appropriate school.

We, the undersigned, release Mountain Home, Cotter, Flippin, Norfork Public Schools, Baxter Regional Medical Center, its employees and the medical staff from any and all liability as a result of the physical examination performed, as well as any negative consequences that may occur after the exam due to information not being revealed during the exam.

Parent or
Guardian's Signature _____ Date _____

BAXTER
HEALTH

Name:_____ School:_____ Sports:_____

BAXTER HEALTH

Pre-participation Physical Evaluation

Name: _____ Date of Birth: _____

Height: _____ Weight _____ % Body fat (optional) _____ Pulse _____ B/P ___/___ (__/__, __/__)

Vision: R 20/_____ L 20/_____ Corrected: Y or N Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
*Stationed-based examination only			

CLEARANCE

- ❑ Cleared
- ❑ Cleared after completing evaluation/rehabilitation for: _____
- ❑ Not cleared for: _____ Reason:_____

Recommendations:_____

_____

Name of Physician: (print/type) _____

Signature of Physician: _____ M.D. or D.O.

Date Seen by Physician: _____

HISTORY **Date of Exam:** _____

Name: _____ Sex: • M • F Age: _____ Date of Birth: _____

Grade next year: _____ School: _____ Sports: _____

Address: _____ Phone: _____

Personal Physician: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone: (H) _____ (W) _____

Explain "YES" answers below. Circle questions you don't know answers to.	**YES**	**NO**
1. Have you had a medical illness or injury since your last check-up or sports physical?		
2. Have you ever been hospitalized overnight?		
3. Are you currently taking any prescription or non-prescription medications or pills or using an inhaler?		
4. Do you have any allergies (for example: to pollen, medicine, food or stinging insects).		
5. Have you ever passed out during or after exercise?		
6. Have you ever been dizzy during or after exercise?		
7. Have you ever had chest pain during or after exercise?		
8. Do you get tired more quickly than your friends during exercise?		
9. Has your heart ever raced or skipped heartbeats?		
10 Have you ever been told you have a heart murmur?		
11 Has any family member/relative died of heart problems or of sudden death before age 50?		
12 Have you had a severe viral infection (for example: myocarditis or monomucleosis) within the last month?		
13 Has a physician ever denied or restricted your participation in sports for any heart problems?		
14 Do you have any current skin problems (for example: itching, rash, acne, warts, fungus, blisters)?		
15 Have you ever had a head injury or concussion?		
16 Have you ever been knocked out, become unconscious or lost your memory?		
17 Have you ever had a seizure?		
18 Do you have frequent or severe headaches?		
19 Have you ever had numbness or tingling in your arms, hands, legs or feet?		
20 Have you ever had a stinger, burner or pinched nerve?		
21 Have you ever become ill from exercising in the heat?		
22 Do you cough, wheeze or have trouble breathing during or after activity?		
23 Do you have asthma?		
24 Do you have seasonal allergies that require medical treatment?		

Explain "YES" answers here:

	YES	**NO**
25 Do you use any special protective/corrective equipment/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)?		
26 Have you had any problems with your eyes or vision?		
27 Do you wear glasses, contacts or protective eye wear?		
28 Have you ever had a sprain, strain or swelling after injury?		
29 Have you broken or fractured any bones or dislocated any joints?		
30 Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?		

If yes, circle appropriate item and explain:

head	elbow	hip
neck	forearm	thigh
back	wrist	knee
chest	hand	shin/calf
shoulder	finger	ankle
upper arm		foot

_____

31 Do you want to weigh more or less than you do?		
32 Do you lose weight regularly to meet weight requirements for your sport?		
33 Do you feel stressed out?		

34 Record dates of your most recent immunizations for?

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

FEMALES ONLY:

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?

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: _____