3 3 2 4 P

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Athlete Participation Examination

If your child needs an athletic participation form filled out by their provider, please complete the request form below. If the request is for an Illinois High School Association form, Town & Country Pediatrics can provide it for you. All other program specific forms should be provided by you. Please remember to complete the parent and athlete portion (page 1) before returning the IHSA form to your school.

If your child has not been seen within the last 12 months for a check-up, you will be asked to complete a visit before the form can be finished.

Please allow Town & Country Pediatrics up to 10 business days to complete your child's form.

Please complete the information below, sign and date where indicated. Your signature represents that you are the legal parent or guardian of the minor child who is Town & Country Pediatrics patient. You therefore act as the minor child's personal representative as HIPAA defines that term. That means that you may have access to the minor child's Protected Health Information. You agree to notify Town & Country Pediatrics if your status as the minor child's personal representative changes for any reason. In unusual circumstances HIPAA may prohibit Town & Country Pediatrics from continuing to provide you with such access to the minor child's Protected Health Information. If those unusual circumstances ever arise, then Town & Country Pediatrics will explain why.

Please provide the following information:

PATIENT INFORMATION	**TODAY'S DATE:**
Last Name:	First Name:
Gender: ☐ Male ☐ Female	DOB:

PARENT/GUARDIAN		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Telephone #:	Cell Phone #:	

DELIVERY METHOD			
☐ **Pick Up** *(Select location below)*	☐ **Mail** *(Enter Mailing Address below)*	☐ **Email *** *(Enter Email Address below)*	
Pick Up Location:	☐ Halsted Location	☐ Lincoln Avenue Location	☐ Glenview Location
Mailing Address:			
Email Address:			

NAME OF PERSONAL REPRESENTATIVE: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

RELATIONSHIP: _____ **DATE:** _____ **TIME:** _____

*****By checking this box, I agree to receive email communication that may contain protected health information. I understand that email transmissions cannot be guaranteed to be delivered, secured or error-free despite best efforts of sender. Sender does not accept liability for errors resulting from transmission.

Halsted
1460 N. Halsted Street
Suite 402
Chicago, IL 60642
(312) 227-2800 *Office*
(312) 227-9551 *Fax*
tcpofficehalsted@luriechildrens.org

Lincoln
6374 N. Lincoln Avenue
Suite 204
Chicago, IL 60659
(312) 227-2860 *Office*
(312) 227-9557 *Fax*
tcpofficelinc@luriechildrens.org

Glenview
2601 Compass Road
Suite 120
Glenview, IL 60026
(312) 227-2850 *Office*
(312) 227-9555 *Fax*
tcpofficeglen@luriechildrens.org

Lurie Children's Primary Care
Town & Country Pediatrics
Athlete Participation Examination

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Medical Record No.
Patient Name
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Physician
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Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ School Year_____
Last First Middle

Address_____ City/State_____

Phone No._____ Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____ Phone No._____

Address_____ City/State_____

HISTORY FORM

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: D Asthma D Anemia D Diabetes D 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: D High blood pressure D A heart murmur D High cholesterol D A heart infection D 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. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. 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**_____

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Lurie Children's Primary Care
Town & Country Pediatrics
Athlete Participation Examination

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Medical Record No.
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PHYSICAL EXAMINATION FORM

Name_____
Last First Middle

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.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.
Yes No Limited Examination Date
Additional Comments:

Physician's Signature Physician's Name

Physician's Assistant Sig nature* PA's Name

Advanced Nurse Practitioner's Signature* ANP's Name

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that al lows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
20___-20___ school term

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at
http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

Signature of student-athlete Date Signature of parent-guardian Date