PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM

To Be Completed by the Student: Check Box Below and complete ALL Fields. The Preparticipation Physical Evaluation Medical Eligibility Form is the ONLY form that should be submitted to St. John's University.

☐ I give the St. John's University Student Health Services Office permission to contact the medical provider who completed this form.

Student's Name: _____

Student's Address: _____

City/Town: _____ Zip Code: _____

Student's Telephone number: (H) _____ (C) _____

Student's email address: _____

X Number: _____

Student Signature: _____ Date: _____

To Be Completed by Health Care Provider: The Preparticipation Physical Evaluation Medical Eligibility Form is the ONLY form that should be submitted to St. John's University.

Student Name: _____ Date of Birth: _____

X-number: _____

Allergies: _____

_____

Medications: _____

_____

_____

Other Pertinent information:

_____

_____

Emergency Contact Name & Phone Number:

_____

Provider to select one of the following:

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

☐ Medically eligible for certain sports

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations:

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): _____

Date: _____

Address: _____

Phone: _____

Health care professional's License Number: _____

Practice State: _____

Signature of health care professional: _____**MD, DO, NP, or PA**

Health Care Provider Stamp:

NOTE: THE BELOW SECTION IS NOT A FORM THAT SHOULD BE COMPLETED OR SUBMITTED TO ST. JOHN'S UNIVERSITY.

Instructions:

1) **STUDENTS:** Please give this guidance sheet to the medical professional (MD, DO, NP, or PA) completing your sports physical.
2) **MEDICAL PROFESSIONALS:**
   - **a)** You may use this guidance sheet for your own personal use. **IT IS NOT TO BE FILLED OUT AND RETURNED TO THE UNIVERSITY.**
   - **b) The only forms that are to be returned to St. John's university is the "PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM" located on page 1 & 2 of this packet.**
   - c) The American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine recommend you screen students who are requesting a sports physical for the following items. If a patient answers yes to any of the questions below, this warrants further investigation by the medical provider providing clearance.

Patient History:

1) Student Name
2) Date of Birth
3) Date of Examination
4) Sex assigned at birth
5) How a student identifies their gender
6) List of past and current medical conditions
7) Surgical History
8) Prescription and OTC medications the student is taking
9) Allergies (I.e. medicines, pollens, food, stinging insects)
10) PHQ-4 Evaluation

General Questions:

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 illness?

Heart Health Questions about the patient:

1. Have you ever passed out or nearly passed out during or after exercise?
2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
3. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?
4. Has a doctor ever told you that you have any heart problems?
5. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.
6. Do you get light-headed or feel shorter of breath than your friends during exercise?
7. Have you ever had a seizure?

Heart Health Questions About the Patient's Family:

1. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
2. 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)?
3. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

Bone and Joint Questions:

1. 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 game?
2. Do you have a bone, muscle, ligament, or joint injury that bothers you?

Medical Questions:

1. Do you cough, wheeze, or have difficulty breathing during or after exercise?
2. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
3. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
4. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicilli n -re si s tan t Staphyloco ccus aureus (MRSA)?
5. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?
6. 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?
7. Have you ever become ill while exercising in the heat?
8. Do you or does someone in your family have sickle cell trait or disease?
9. Have you ever had or do you have any problems with your eyes or vision?
10. Do you worry about your weight?
11. Are you trying to or has anyone recommended that you gain or lose weight?
12. Are you on a special diet or do you avoid certain types of foods or food groups?
13. Have you ever had an eating disorder?

Females only:

1. Have you ever had a menstrual period?
2. How old were you when you had your first menstrual period?
3. When was your most recent menstrual period?
4. How many periods have you had in the past 12 months?

Physical Examination Should include:

1. Height, Weight, Blood Pressure, Pulse, Vision screening, COVID-19 vaccine dates (primary, secondary and booster), Appearance (do they have Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency), ENT evaluation, PERRLA, Basic Hearing evaluation, Lymph node evaluation, Heart evaluation (auscultation for murmurs while standing, supine and with Valsalva maneuver, Lung evaluation, Abdomen evaluation, Skin evaluation (screen for Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis), Neurological evaluation, Musculoskeletal (Neck, Back,

Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Leg, Ankle, Foot, & Toes) evaluation, Functional (Double-leg squat test, single-leg squat test, and box drop or step drop test).

2. Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.