To: All Parents of Bartlett High School Athletes in grades 9-12 for the 2018-19 school year

From: Jim Steinbrecher & Joey Nesbit, Athletic Directors

Re: Campbell Clinic Physicals

Date: April 2018

What: Campbell Clinic Comprehensive Athletic Physicals
When: **Sat, May 5th** –Bartlett High School's time is **9:45am**
Where: Campbell Clinic, 1400 S. Germantown Rd.
Cost: **$10 cash**

Why do this?

Campbell Clinic Physicals

- Physicals will cover the 2018-19 school year
- Athletes will be examined by at least two physicians—internal medicine and orthopedics
- Important Note: Parents need to attend if at all possible—there will be a hernia check—in the room, there will be either one doctor and a parent or two doctors if no parent is present.

What I need from each athlete's family:

- **$10 cash before Wed, May 3rd**
  Main Campus--Coach Steinbrecher's room, M-213;
  Academy--Coach Patterson's room(504); on/after 4/23, Gymnasium

- Athletes will receive a receipt and a parent physical packet when they pay; they will **bring** the filled-out Campbell Clinic packet with them on Saturday, May 5th to Campbell Clinic.

Questions? jsteinbrecher@bartlettschools.org--848-1896

Campbell Clinic

SPORTS MEDICINE

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*Some pages need parent and athlete signatures.

① 9:45 (arrive early) Sat, May 5th

② $10 cash

③ Sign the bottom of + fill out:
- pg. 3 (HISTORY)*
- pg. 4 (Consent + Emergency Info)
- pg. 5 (Campbell Concussion Policy)
- pg. 6 (HIPAA)
- pg. 7 (Sudden Cardiac Arrest - SCA - State of TN)
- pg. 8 (Physical Exam Limitation - sign in middle - + Campbell Privacy - sign @ bottom, if needed)
- pg. 9 → FOR DRS. usage only
Write ① grade, name + date (+ school if blank)

Dear Parents:

Campbell Clinic is again pleased to be able to offer pre-participation medical screenings for the 2018- 2019 school year. The physicals will be held at our Germantown office location on Saturday, May 5, 2018. The cost of the physical will be $10 and will need to be paid to the school in advance. Each school will have a designated time to be present, please contact your school's Athletic Director for your time. **(The Bartlett High School time is 9:45a)**

The process we use for athletic physical screenings is determined by our Sports Medicine Committee. This committee reviews the latest literature from the American College of Sports Medicine, the American Medical Association, and the subspecialty groups relating to pediatrics and family medicine. Their guidelines, which are considered standard medical practice, are followed in our physical screenings. The pre-participation physical will include the following: An orthopedic exam, a general medical exam by a family medicine physician, as well as blood pressure, pulse, height, weight, and vision screenings. **Note:** ***If you have corrected vision, please wear glasses or contact lenses to the screening.***

Each screening is subsequently reviewed by a fellowship trained and board certified Sports Medicine physician. Any athlete who has a questionable finding will be instructed to follow up with their family physician so that this finding is properly addressed and recorded in that child's medical record. The most common reasons for non-clearance and referral to family M.D. include: heart abnormalities, uncorrected vision and high blood pressure. In these cases, their own physician is better suited to determine fitness for participation, and the athlete will not be cleared from our M.D's.

This physical screening is **not** a substitute for an annual physician checkup. We recommend every adolescent visit their family physician for a yearly checkup in addition to having a pre-participation physical. Our intent is to provide a comprehensive athletic medical screening and to clear for participation those athletes who have no questionable findings.

Thank you for your participation and I hope that this letter clarifies our process. If you have any questions or concerns, please feel free to call me at 901-759-3180.

Sincerely,

Owen Golden MS, ATC, LAT, PES
Athletic Training Coordinator

John Hyden, M.D.
Medical Director for Physicals

④ Bring completed packet with you to Campbell Clinic on Sat, May 5th

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam May 5, 2018

Name ______________________ Date of birth ______________

Sex ______ Age ________ Grade ________ School Bartlett High 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 ________

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CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name ______________________ First Name ______________________ MI ______

Sex: [ ] Male [ ] Female Grade __________ Age ______ DOB ___/___/____

Allergies ____

Medications ____

Insurance ______________________ Policy Number ______________________

Group Number ______________________ Insurance Phone Number ______________________

Emergency Contact Information

Home Address ______________________ (City) ______________ (Zip) ________

Home Phone ______________ Mother's Cell ______________ Father's Cell ______________

Mother's Name ______________________ Work Phone ______________________

Father's Name ______________________ Work Phone ______________________

Another Person to Contact ____

Phone Number ______________________ Relationship ______________________

Legal/Parent Consent

I/We hereby give consent for (**athlete's name**) ______________________ to represent (**name of school**) Bartlett High School in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

______________________ ______________________ ______________________

Signature of Athlete **Signature of Parent/Guardian** **Date**

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Campbell Clinic Concussion Policy for High School Athletes

Concussion is a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces.

Several common characteristics:

- Headache
- Cognitive impairment
- Emotional liability
- Dizziness
- Blurred vision
- Loss of consciousness or amnesia
- Sleep disturbances- tired
- Sensitive to light and sound
- Nausea

New guidelines and best practice suggestions were discussed in Zurich in 2012, and many organizations including the NCAA and TSSAA have developed some new policies in reaction to the Zurich conference. Some important conclusions included that there should be no same day return to play with the diagnosis of concussion and that treatment of athletes <18 should be more conservative than that of adult athletes. Ideally, neuropsychological testing (ie. Impact, SCAT2) plays an important role in concussion management; however at the high school level most schools do not have access to this type of testing. The TSSAA has developed a policy for officials mandating that they remove any player exhibiting signs of concussion from play. That player cannot return to play the same day unless they are evaluated by a physician who must fill out and sign a "TSSAA Concussion Return to Play" form.

Our policy:

1. No same day return to play with the diagnosis of concussion.
2. Every athlete experiencing a concussion needs to be evaluated by a member of the sports medicine team as soon as possible. (ATC or physician if available)
3. Appropriate same day management should then be determined. (assess the need to go to the ER, handout with signs to look out for)
4. There may be a time of rest necessary before return to activity that can include both physical and mental rest.
5. Once asymptomatic a decision should then be made among the sports medicine team when the athlete can begin the graduated return to play protocol below. (Preferably there would be 24 hours between each step)

    a) No activity until asymptomatic.

    b) Low impact activity x 10 mins; Rest 20 mins; Repeat if asymptomatic Aerobic activity: 1 40 yd sprint followed by 10 jumping jacks / squats / situps / pushups; Rest 30 mins; Repeat if asymptomatic. Allowed to participate in lifting exercises w/ team.

    c) Sport- Specific Non-Contact drills: Running through plays / agility bag work etc

    d) Full Contact drills: ie. Sled blocking, pad blocking / tackling, one-on-one drills

    e) Return to game/play.

6. Every athlete diagnosed with a concussion must be evaluated by a physician or neuropsychologist before beginning the graduated return to play protocol.

I, ______________________, parent/legal guardian of ________________________, have received and understand the signs/symptoms and return to play guidelines as stated in the Campbell Clinic Concussion Policy.

______________________________	______________________________
Athlete's Name/Signature	Parents Name/Signature
______________________ Date	______________________ Date

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Student-Athlete Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, physical therapists and sports medicine personnel representing Campbell Clinic to disclose protected health information regarding any injury or illness affecting the student-athlete's training for and participation in athletics at Bartlett High School. Campbell Clinic is authorized to disclose this protected health information to any coach, the athletic director, or any school official in connection with his/her participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be disclosed to other health care providers within the Campbell Clinic system; to Bartlett High School Administrators; and to officials of the Tennessee Secondary School Athletic Association.

I, ______________________, parent or guardian of ________________________,
(name of parent/guardian) (name of student)
understand that parent/legal guardian authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at High School and for care during interscholastic athletics. I understand that my child's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). This protected health information may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing Campbell Clinic. If authorization or consent is revoked, it will not have any effect on the actions Campbell Clinic personnel took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent is enacted on the date of signature and expires on May 31, 2019. Campbell Clinic will not condition your treatment on the signing of an authorization, except for any possible research-related treatment.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

______________________________ ______________________________
Print Student-Athlete's Name Signature of Parent/Legal Guardian

____
Date

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?
Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States? SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act
The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  - (i) Unexplained shortness of breath;
  - (ii) Chest pains
  - (iii) Dizziness
  - (iv) Racing heart rate
  - (v) Extreme fatigue

- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete	Print Student-Athlete's Name	Date
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

IV. To Parent/Guardian—Physical Examination Limitation

The physicians of Campbell Clinic would like to inform you that this athletic physical examination is intended only as a screening exam. It is the standard physical examination that is required by the Tennessee Secondary Athletic Association for participation in high school athletics. It is not intended to replace standard medical care by your family physician. The exam of the heart and lungs is performed by the use of auscultation only (stethoscope).

Cardiac conditions that result in "sudden cardiac death" are very infrequent—1 in 135,000 (male) and 1 in 750,000 (female) . However, most of these cardiac conditions in athletes can not be identified solely by the use of a stethoscope. Specialist care that goes beyond this standard physical examination is available in the Memphis medical community. The Campbell Clinic Sports Medicine Team will be glad to help refer your child to a Cardiology specialist at your request.

Parent/Guardian: Please initial one or both of the following statements and sign below. Your initials and signature are required for completion of the physical examination.

- ☐ I understand the limitations of the standard pre-participation exam and wish for my child to proceed with this examination.
- ☐ I would like a formal echocardiogram and cardiac stress test to be arranged with a cardiologist at my expense for a more in depth cardiac examination.

______________________________ ______________________

Parent's Signature Date

Campbell Clinic Privacy Information

The Athletic Director has been provided with copies of Campbell Clinic's Health Information Privacy Policy. The athletic director will provide you with a copy upon request. If you choose to receive a copy, please sign below to acknowledge that you have received this information. **You are not required to receive or acknowledge receipt of the information to have your child's physical examination performed.**

I, ________________________, do hereby acknowledge receipt of Campbell Clinic's Patient Notice on

Parent's Name

____________________.

Date

____

Parent's Signature

General Physical Examination

Name______________________________ School Bartlett High School Grade___________

Date_________________

Information below is to be completed by medical staff only.

Height _______________ Weight ______________ BP __________/__________ Pulse__________

Vision R 20/_____ L 20/_____ Corrected? _____ Yes _____ No Pupils __________

Musculoskeletal Examination
Examiner:________________________________

Been to Physician in past 2 years for muscle, joint, or bone pain? ____No Yes____

	Normal	Abnormal Findings
Neck/Back		
Upper Extremities		
Lower Extremities		
General Strength		
General Flexibility		

General Notes/Other:

Internal Medicine
Examiner:________________________________

	Normal	Abnormal Findings
Ears, Nose, Throat		
Heart		
Chest/Lungs		
Skin/Lymphatic		
Abdominal		

General Notes/Other:

Official Recommendation

This athlete _____ may _____ may not compete in athletics based on the data gathered from this exam.

Prior to participation, treatment or follow-up on the following is **recommended / required:**

Recommend further consultation with

____

Examiner: (print) ______________________________

(sign)________________________________Date:__________