病歷表 | 參加前的身體評估

(註:在見醫療服務提供者前,病人及其家長要填寫本表格。醫療服務提供者應該將本表格存入學生的醫療檔案中。本表格不會交回到體育教研組。)

檢查日期				出生日期	OSIS號碼:
姓氏		名字			運動
性別	年齡	年級	學校	學校校園	

藥物和過敏

請列出你現在服用的所有處方藥和非處方藥和營養補充品(草本補充品和營養補充品)。

你是否隨身攜帶吸入器? ❑ **是** ❑ **否**

你是否有過敏? ❑ **是** ❑ **否** 如果回答「是」,請在下面標明具體的過敏:
❑ 藥物過敏 _____ ❑ 花粉過敏 ❑ 食物過敏 _____ ❑ 昆蟲叮咬過敏 ❑ 乳膠過敏

你是否隨身攜帶Epi Pen? ❑ **是** ❑ **否**

如果回答「是」,請在下面解釋。請圈選你不知道答案的問題:

一般問題		**是**	**否**
1.	醫生是否曾經因為任何原因拒絕或限制你參加體育活動?		
2.	你是否一直有任何健康問題?如果回答「是」,請在下面標明: ❑ 哮喘 ❑ 貧血 ❑ 糖尿病 ❑ 傳染病 ❑ 鐮狀紅血球疾病或特徵 其他: _____		
3.	你是否曾經入院?		
4.	你是否做過手術?		
關於你的一些心臟健康問題		**是**	**否**
5.	你做運動時或做運動之後是否曾試過暈倒或幾乎暈倒?		
6.	你做運動時,胸口是否曾經感到不舒服、痛楚、緊縮或有壓迫感?		
7.	你在靜止休息或做運動時,心臟是否曾急速跳動或漏跳?		
8.	你的醫生是否曾跟你說你有任何心臟毛病?如果回答「是」, 請勾選所有適用項: ❑ 高血壓 ❑心臟雜音 ❑ 高膽固醇 ❑ 心臟感染 ❑ 川崎氏病(黏膜皮膚淋巴腺綜合症) 其他: _____		
9.	醫生是否曾經為你安排心臟檢查? (例如:ECG/EKG、心臟超音波檢查)		
10.	你在做運動時是否感到頭重腳輕或呼吸得比預期的更加急促?		
11.	你在做運動時是否比朋友覺得更累或更快就出現呼吸急促?		
12.	你是否曾做過任何心臟手術?		
有關你家庭的心臟健康問題		**是**	**否**
13.	你家庭中是否有人有心律不整?		
14.	你是否有家人或親戚死於心臟問題,或者突如其來、莫名其妙在50歲前猝逝(包括溺斃、莫名其妙的車禍或嬰兒猝死症)?		
15.	你家裡是否有人有心臟問題、要使用心臟起搏器或去顫電擊器?		
16.	你家裡是否有人曾經有莫名其妙的暈眩、癲癇或幾乎遇溺?		
17.	你自己或家裡是否有人有鐮狀細胞特徵或疾病?		
有關骨骼和關節的問題		**是**	**否**
18.	你是否因骨頭、肌肉、韌帶或肌腱受傷而導致錯失練習機會或不能比賽?		
19.	你是否有過任何斷骨、骨折或關節扭傷?		
20.	你是否試過因受傷而需要照X光、照MRI、CT掃瞄、注射、接受治療、使用支撐用具、打上石膏或支撐拐杖?		
21.	你是否曾經有疲勞性骨折(應力性骨折)?		
22.	是否有人曾告訴你,你有頸骨不穩定?或者你是否因頸骨不穩定而要照X光?(唐氏症或侏儒症)		
23.	你是否經常使用支撐器、矯正器或其他設備?		
24.	你骨頭、肌肉或關節受的傷是否令你覺得很不舒服?		
25.	你是否有幼年關節炎或結締組織疾病?		
26.	你的關節是否變得很痛、腫脹、發熱或發紅?		
27.	你做運動時或之後是否出現咳嗽、氣喘或呼吸困難?		

醫療問題		**是**	**否**
28.	你是否曾經使用過吸入器或服用過哮喘藥物?		
29.	你家人是否患有哮喘?		
30.	你是否天生沒有或者後來失去了腎臟、眼睛、睪丸(男性)、脾臟或任何其他器官?		
31.	你是否有鼠蹊部疼痛(groin pain)、腫脹或者在鼠蹊部位有疝氣?		
32.	你在上個月內是否患上傳染性單核白血球增多症(infectious mononucleosis,又稱作mono)?		
33.	你是否有任何紅疹、褥瘡(壓瘡)或其他皮膚問題?		
34.	你是否曾患上皰疹或金黃色葡萄球菌(MRSA)皮膚感染?		
35.	你的頭部是否受過傷或有過腦震盪?		
36.	你是否出現過莫名其妙的癲癇?		
37.	你的頭部是否曾遭受過擊打或毆打而導致神志不清、持久頭痛或記憶力出現問題?		
38.	你是否有癲癇發作的病歷?		
39.	你做運動時是否會頭痛?		
40.	你在被擊打或跌倒後,手臂或腿部是否曾感到麻痺、刺痛或無力?		
41.	你在被擊打或跌倒後,是否曾無法移動四肢?		
42.	你在高溫下做運動時是否曾感到不舒服?		
43.	你在做運動時,肌肉是否經常會抽筋?		
44.	你的眼睛或視力是否曾有過任何問題?		
45.	你的眼睛是否曾受過傷?		
46.	你是否戴眼鏡或隱型眼鏡?		
47.	你是否配戴保護性質的眼鏡,例如護目鏡或面罩?		
48.	你是否曾喪失過聽力,或聽力是否出現過問題?		
49.	你是否擔心自己的體重?		
50.	你是否想增重或減重,或是有任何人建議你這樣做?		
51.	你是否在吃特別的餐單或你想戒吃某類食物?		
52.	你是否有過飲食失調?		
53.	你是否有什麼憂慮想要跟醫生討論的?		
54.	你是否有任何其他健康問題?		
只限女性		**是**	**否**
55.	你是否有過月經?		
56.	你來經時是否曾有過任何問題(嚴重的抽痛、流量很多)?		
57.	你上次幾時來月經? _____		
58.	你多久來一次月經? _____		

如果回答「是」,請在這裡說明

我已查看病歷表,並在此聲明,盡我所知,以上問題的回答都是完整正確的。我同意 _____ (**子女姓名**) 接受體檢,男生的話,該體檢包括鼠蹊部位(附近)和睪丸的檢查,女生的話,該體檢包括鼠蹊部位(附近)的檢查。如果檢查在學校內進行,我明白如果我本人或我的子女拒絕讓這些部位接受檢查,學校健康辦公室的醫療服務提供者將不能填妥本表格,以及認可我子女參加了體檢。

家長/監護人姓名	
家長/監護人簽名	日期
電話號碼	

PHYSICAL EXAMINATION FORM | Preparticipation Physical Evaluation

NOTE: The medical provider should keep this form in the student's medical file. This form does not get returned to the athletic department.

Last Name	First Name	Date of Birth

School/Campus/ATSDBN	Grade	OSIS#

STUDENT'S HISTORY FORM REVIEWED BY MEDICAL PROVIDER	**YES NO**
PHYSICIAN REMINDER - Consider the questions below	**COMMENTS**
Do you feel safe at your home or residence?	
Do you feel safe at school?	
Do you ever feel stressed out or under a lot of pressure?	
Do you ever feel sad, hopeless, depressed, or anxious?	
Have there been any changes in your weight?	
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
Have you ever taken anabolic steroids or used any other performance supplement?	
Have you ever tried cigarettes, alcohol, or other drugs?	
During the past 30 days, did you use cigarettes, alcohol or other drugs?	
Are you sexually active?	
Are you using contraceptives?	
Do you wear a seat belt?	

EXAMINATION

Height	Weight	❑ Male ❑ Female

BP	Pulse	Vision	Corrected
_____ / _____		R20/ _____ L20/ _____	❑ Yes ❑ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP)		
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	NORMAL	ABNORMAL FINDINGS
Neck		
Back (including scoliosis screening)		
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] GU exam must be done in a private setting; the presence of a third party/chaperone is needed. It should not be performed in mass participation settings. [c]consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) outlined on the Recommendations for Participation in Physical Education and Sports form. This form may be rescinded until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Date	License/NPI Number
Address	Phone	
Signature of Medical Provider ,MD/DO/NP/PA		STAMP HERE

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

Last Name	First Name	OSIS#	Grade

School/Campus/ATSDBN

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**

❑ **NOT CLEARED** **Duration:** _____

❑ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____

_____

❑ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

❑ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

❑ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

❑ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

❑ **OTHER RESTRICTIONS** _____

_____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

❑ None ❑ Athletic Cup ❑ Sports/Safety Goggles ❑ Medical/Prosthetic Device ❑ Pacemaker ❑ Insulin Pump/Insulin Sensor
❑ Brace/Orthotic ❑ Hearing Aides ❑ Protective Ear Gear ❑ Other _____

❑ **PERTINENT MEDICAL HISTORY** _____

❑ **ALLERGIES** _____ ❑ None

MEDICATIONS

❑ Has prescribed pre-exercise medication _____

❑ Has prescribed PRN medication _____

❑ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

_____

❑ **OTHER RECOMMENDATIONS** _____

_____

_____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI

Address	Medical Provider's Stamp

Phone	Fax	Email

Signature of medical provider	Date