CRMC

COOKEVILLE REGIONAL
MEDICAL CENTER

SPORTS MEDICINE

**215 W 6th Street**
**Cookeville, TN 38501**
**931-783-2900**

www.crmchealth.org

# To student athletes and their parents/caregivers:

Before you can play a sport, the TSSAA (Tennessee Secondary School Athletic Association) says you must get a sports physical. This is also called a PPE (Preparticipation Physical Evaluation). The PPE promotes the health and well-being of athletes as they train and compete. It also helps keep athletes safe as they play sports. It is NOT meant to stop them from playing.

Where can you go to get a PPE? In the newest PPE guidebook, the groups below say your doctor's office or the place where you get your medical care is where you can go to get it done:

- the American Academy of Pediatrics,
- the American Academy of Family Physicians,
- the American College of Sports Medicine,
- the American Medical Society for Sports Medicine,
- the American Orthopedic Society for Sports Medicine,
- and the American Osteopathic Academy of Sports Medicine.
- It's also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations.

**There are other places you can get a PPE, but we recommend athletes get a PPE during their Well Visit at their doctor's office or School Based Health Center.**
This ensures exams cover everything important about your overall health and well-being. It also limits absences from school and sports.

We encourage you to work the PPE into the routine health care you get at your doctor's office or the place where you get your medical care. If you're enrolled in TennCare your well visits are free.

Sincerely,

Tennessee Secondary School Athletic Association
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Division of TennCare

***Do you have TennCare and need to know who your doctor is?***

**You can call your MCO at:**
Amerigroup: 1-800-600-4441
BlueCare: 1-800-468-9698
United.Healthcare: 1-800-690-1606
TennCareSelect: 1-800-263-5479

**Cookeville Regional Medical Center is proud to serve the community with a variety of invaluable healthcare needs.**

**One of those services is providing sports medicine services to athletes at the three high schools in Putnam County.**

***We have three sports medicine specialists who will be working with all of your high school athletes:***

**Christopher Loubier** *(Cookeville High School)* is a graduate of Georgia State University and is a certified athletic trainer.

**Allan Malone** *(Upperman High School)* is a graduate of the University of North Carolina-Greensboro and is an adjunct instructor in the pre-athletic training program at Tennessee Tech.

**Candy Mickey** *(Monterey High School)* is a graduate of California University in Pennsylvania. She has worked with various sports teams as an athletic trainer.

***We have multiple physicians on staff with sports medicine board certifications and training at Tier One Orthopedics and Neurosurgical Institute located at 105 S Willow Avenue.***

**Dr. Derek Worley**
Sports Medicine Board Certified

**Dr. Michael Pahl**
Orthopedics and Sports Medicine Board Certified

**Dr. Ken Grinspun**
Orthopedics and Sports Medicine Board Certified

**Dr. Greg Roberts**
Orthopedics and Sports Medicine Board Certified

**Dr. John Turnbull**
Orthopedics Board Certified

**Dr. Shawn Stachler**
Orthopedics Board Certified

*These physicians have had numerous years of experience and training in sports medicine, concussion protocols and orthopedic related issues.*

They have served on staff with the following organizations: New York Jets, Philadelphia Eagles, Philadelphia Phillies, University of Arkansas, Long Beach State University, UT Chattanooga. The physicians have also served the sports medicine needs of many local high schools.

***Get Your Sports Physical Today!***

**COOKEVILLE REGIONAL URGENT CARE**
**7 days a week, 7 a.m. to 7 p.m. • 931-783-5353**

We value the relationship we have with the Putnam County School system and we –

- have everything that is needed to treat your student athlete and any type of sports injury
- have outpatient therapy services at the Cookeville Regional Medical Center Blue Roof building at 215 W 6th St.
- offer a variety of therapies for your student athlete, in a professional environment, to get them back to the game
- are here to deliver the best healthcare in the Upper Cumberland.

***Thank you for trusting us with your Family's needs!***

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**215 W 6th Street**
**Cookeville, TN 38501**
**931-783-2900**
https://crmchealth.org/outpatient-rehabilitation

***Do You Have Questions?***

Contact Shona Davis-Smith, Director of Therapy Services at 783-2459

# HISTORY FORM

***Note: Complete and sign this form (with your parents if younger than 18) before your appointment.***

Name:_____Date of birth: _____

Date of examination:_____Sport(s):_____

Sex assigned at birth (F, M, or intersex):_____How do you identify your gender? (F, M, or other):_____

List past and current medical conditions: _____

_____

Have you ever had surgery? If yes, list all past surgical procedures: _____

_____

Medicines/Supplements: List all current prescriptions, over-the-counter medicines, supplements (herbal and nutrition)

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects)

_____

_____

## PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)

***Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)***

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

*(A sum of ≥3 is considered positive on either subscale (questions 1 and 2, or questions 3 and 4) for screening purposes.)*

| **GENERAL QUESTIONS**<br>(Explain "Yes" answers at the end of this form.<br>Circle questions if you don't know the answer.) | **Yes** | **No** |
|---|---|---|
| 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 YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |

| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No |
|---|---|---|
| 11. 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)? | | |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marlon syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardio (CPVT)? | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 14. 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? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problem? | | |
| 21. Have you ever had numbness, hand tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in the heat? | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | | |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

***I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.***

Signature of Athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

# PHYSICAL EXAMINATION FORM

Name:_____Date of birth: _____

**PHYSICIAN REMINDERS:**

1. *Consider additional questions on more-sensitive issues*
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. *Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form)*

| **EXAMINATION** | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency) | | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis | | |
| Neurological | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back | | |
| Shoulder and arm | | |
| Elbow and forearm | | |
| Wrist, hand, and fingers | | |
| Hip and thigh | | |
| Knee | | |
| Leg and ankle | | |
| Foot and toes | | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

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

Name of health care professional (print or type):_____Date:_____

Address:_____ Phone: _____

Signature of health care professional _____MD, DO, NP, or PA

# MEDICAL ELIGIBILITY FORM

Name:_____Date of birth: _____

- ❑ 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 or type):_____Date:_____

Address:_____ Phone: _____

Signature of health care professional _____MD, DO, NP, or PA

## SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information:_____

_____

_____

Emergency contacts:_____

_____

_____

# CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

## ATHLETE INFORMATION

_____ _____ _____
LAST NAME FIRST NAME MI

Sex: ❑ Male ❑ Female Grade: _____ Age: _____ DOB: _____ / _____ / _____

Allergies: _____

Medications: _____

Insurance: _____ Policy #: _____

Group #: _____ Insurance Phone #: _____

## 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: _____

Relationship: _____ Phone Number: _____

## LEGAL / PARENT CONSENT

I/We hereby given consent for (athlete's name) _____ to represent (name of school) _____ in athletics realizing that such activity involved 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: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

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# STUDENT-ATHLETE AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, the parent or guardian of _____ (the "student athlete"), hereby authorize the certified athletic trainers and/or sports medicine staff representing CRMC Sports Medicine Department to gather and release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's preparation for and participation in athletics at _____ School (the "School"). This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other healthcare providers, hospitals and/or medical clinics and laboratories, athletic trainers, athletic coaches, medical insurance coordinators athletic and/or school administrators and officials of the Tennessee Secondary School Athletic Association.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student-athlete's protected health information may be a condition for the student athlete's participation in interscholastic sports at the School. I understand that the student-athlete's protected health information is protected under Federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the schools athletic director in writing, but if l do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year and ninety days from the date it is signed.

## REQUIRES SIGNATURE FOR AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Print Student-Athlete Name

_____ _____

Signature of Parent / Legal Guardian Date Signed

# STUDENT-ATHLETE AND PARENT/LEGAL GUARDIAN CONCUSSION STATEMENT

***Must be signed and returned to school or community youth athletic activity director prior to participation in practice or play.***

_____
Student-Athlete Name

_____
Parent / Legal Guardian Name(s)

| STUDENT/ATHLETE INITIALS | | PARENT/LEGAL GUARDIAN INITIALS |
|---|---|---|
| | A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available. | |
| | A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury. | |
| | I will tell my parents, my coach and/or a medical professional about my injuries and illnesses. | |
| | I will not return to play in a game or practice if a hit to my head or body causes any concussion - related symptoms. | |
| | I will/my child will need written permission from a *health care provider** to return to play or practice after a concussion. | |
| | Most concussions take days or weeks to get better. A more serious concussion can last for months or longer. | |
| | After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse. | |
| | After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away. | |
| | Sometimes repeat concussion can cause serious and long-lasting problems and even death. | |
| | I have read the concussion symptoms on the Concussion Information Sheet. | |

**Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

Signature of Athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

# Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet

## 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; or

  (v) Extreme fatigue; and

- 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.

**PLEASE SIGN BELOW**

_____

Print Student-Athlete Name

_____

Signature of Parent / Legal Guardian

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