IWS Children's Clinic is partnering with Gwendolyn Brooks Middle School

GET YOUR SPORTS PHYSICALS!

Call to schedule an appointment
at the IWS Children's Clinic at 320 Lake Street in Oak Park
Saturday July 11th
12:30-4:30PM
Saturday August 15th
9:00 AM-4:30 PM

Please call for an appointment and identify that you are requesting a sports physical through Gwendolyn Brooks Middle School ~ IWS Children's Clinic sports physical program.

All students participating in the IWS Children's Clinic Sports Physical Program should bring to the clinic office at the time of their appointment:
1- IHSA Pre-participation Examination form and
2 - IWS Children's Clinic registration form

The charge for the visit will be $40 which can be paid by cash, check or credit card

Call Today 708.848.0528

The IWS Children's Clinic is a full-service pediatric clinic. We provide quality, affordable medical, dental and behavioral child health care services, supporting children from birth through age 18.

OPRF Infant Welfare Society | 320 Lake St. Oak Park, IL 60302 | www.childrensclinicíws.org | 708.848.0528

IWS Children's Clinic

SPORTS PHYSICAL REGISTRATION FORM

Gwendolyn Brooks Middle School

Please call 708.848.0528to schedule an appointment at the IWS Children's Clinic at 320 Lake Street in Oak Park. Identify that you are requesting a sports physical through Gwendolyn Brooks Middle School/IWS Children's Clinic sports physical program on Saturday July 11th 12:30-4:30PM or Saturday August 15th 9 AM-4:30 PM

The IWS Children's Clinic is located at 320 Lake Street Oak Park IL 60302.
All students participating in the IWS Children's Clinic Sports Physical Program should bring to the clinic office at the time of their appointment:

1- This consent form: IWS Children's Clinic **Sports Physical Registration Form**
2- **IHSA Pre-participation Examination form**: The questions on the IHSA Pre-participation Examination form need to be fully completed and the form signed by the parent or legal guardian. Make sure all "yes" answers on the form are explained in the space provided. If further space is needed, please attach an additional sheet of paper. Your child will not be seen if the paperwork is not completed and signed by the parent or legal guardian.
3- Payment: The Charge for the visit will be **$40** which can be paid by cash, check or credit card

Please complete:

Name of Student	
Date of Birth	
Name of Parent or Guardian	
Address	City, State, Zip
Phone	Email

Consent To Treat
I give permission for the IWS Children's Clinic to perform all necessary procedures for a sports physical for my child.

Date ______________________

Parent/Guardian Signature ______________________

Parent/Guardian Printed Name ______________________

After the physical exam please review the visit summary. If further testing is recommended or required, you must follow-up with your child's primary care physician. This sports physical does not replace the recommended annual exam with your child's primary care physician.

Pre-participation Examination

IHSA — Illinois High School Association | IESA

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

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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. 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

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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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Pre-participation Examination

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 Signature* ____________________ 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 allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

IWS Children's Clinic is partnering with Percy Julian Middle School

GET YOUR SPORTS PHYSICALS!

Call to schedule an appointment
at the IWS Children's Clinic at 320 Lake Street in Oak Park
Saturday July 11th
12:30-4:30PM
Saturday August 15th
9:00 AM-4:30 PM

Please call for an appointment and identify that you are requesting a sports physical through Percy Julian Middle School ~ IWS Children's Clinic sports physical program.

All students participating in the IWS Children's Clinic Sports Physical Program should bring to the clinic office at the time of their appointment:
1- IHSA Pre-participation Examination form and
2 - IWS Children's Clinic registration form

The charge for the visit will be $40 which can be paid by cash, check or credit card

Call Today 708.848.0528

The IWS Children's Clinic is a full-service pediatric clinic. We provide quality, affordable medical, dental and behavioral child health care services, supporting children from birth through age 18.

OPRF Infant Welfare Society | 320 Lake St. Oak Park, IL 60302 | www.childrensclinicsiws.org | 708.848.0528g

IWS Children's Clinic

SPORTS PHYSICAL REGISTRATION FORM

Percy Julian Middle School

Please call 708.848.0528 to schedule an appointment at the IWS Children's Clinic at 320 Lake Street in Oak Park. Identify that you are requesting a sports physical through Percy Julian Middle School/ IWS Children's Clinic sports physical program on Saturday, July 11th 12:30-4:30PM or Saturday, August 15th 9 AM-4:30 PM

The IWS Children's Clinic is located at 320 Lake Street Oak Park IL 60302.
All students participating in the IWS Children's Clinic Sports Physical Program should bring to the clinic office at the time of their appointment:

1- This consent form: IWS Children's Clinic **Sports Physical Registration Form**
2- **IHSA Pre-participation Examination form**: The questions on the IHSA Pre-participation Examination form need to be fully completed and the form signed by the parent or legal guardian. Make sure all "yes" answers on the form are explained in the space provided. If further space is needed, please attach an additional sheet of paper. Your child will not be seen if the paperwork is not completed and signed by the parent or legal guardian.
3- Payment: The Charge for the visit will be **$40** which can be paid by cash, check or credit card

Please complete:

Name of Student	
Date of Birth	
Name of Parent or Guardian	
Address	City, State, Zip
Phone	Email

Consent To Treat
I give permission for the IWS Children's Clinic to perform all necessary procedures for a sports physical for my child.

Date

Parent/Guardian Signature

Parent/Guardian Printed Name

After the physical exam please review the visit summary. If further testing is recommended or required, you must follow-up with your child's primary care physician. This sports physical does not replace the recommended annual exam with your child's primary care physician.

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

____

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____

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. 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

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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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Pre-participation Examination

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 Signature* __________ 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 allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.