



# Khám Sức Khỏe Trước Khi Tham Gia Thể Thao

Bộ Giáo Dục Tiểu Bang Maryland  
Bộ Y Tế Tiểu Bang Maryland  
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)  
Rockville, Maryland 20850

MCPS Form SR-8  
Tháng 6, 2019

## Khám Sức Khỏe Trước Khi Tham Gia Thể Thao

Kính gửi Quý vị Phụ huynh hay Giám hộ:

Học sinh học từ lớp 9 đến 12 bắt buộc phải khám sức khỏe mỗi năm trước khi tham gia vào chương trình thể thao liên trường và chương trình tại trường MCPS. Học sinh lớp 7 và 8 phải khám sức khỏe mỗi hai năm để được tham dự vào chương trình thể thao liên trường tại trường trung học cấp hai của MCPS.

Kiểm tra sức khỏe sẽ được người cung cấp dịch vụ y tế có thẩm quyền thực hiện.

Việc kiểm tra sức khỏe trước khi tham dự bao gồm 4 phần: Đơn Lịch sử (trang 1 và 2), Đơn Kiểm tra Sức khỏe (trang 3), Đơn Lực Sĩ với Khuyết Tật: Bổ sung cho Lịch sử Lực Sĩ (trang 4), và Đơn Đủ Điều Kiện Y Tế (trang 5).

**Học sinh chỉ phải nộp trang cuối cùng (MEDICAL ELIGIBILITY FORM- Đơn Đủ Điều Kiện Sức Khỏe, trang 5) cho nhà trường hay huấn luyện viên trước khi tham dự. Người cung cấp dịch vụ sức khỏe có thẩm quyền nên giữ lại bốn trang đầu tiên.**

Nếu một học sinh-lực sĩ trải nghiệm một chấn thương, bệnh tật hoặc giải phẫu đáng kể sau khi nộp bản khám sức khỏe mỗi năm trước khi tham gia vào chương trình thể thao, cần có thư thông báo từ người cung cấp dịch vụ sức khỏe có thẩm quyền để tiếp tục tham gia.

Những tin tức về sức khỏe nộp cho trường chỉ có những nhân viên về sức khỏe và giáo dục liên hệ tới con em quý vị mới được xem.

Trường hợp ngoại lệ không phải khám sức khỏe được cho phép nếu việc này trái với tín ngưỡng của học sinh. Trong những trường hợp này, gia đình nên gửi đơn chứng nhận.

Nếu em học sinh-lực sĩ cần thuốc và/hay một điều trị được thi hành tại trường học hay trong khi thực tập hay các sự kiện thể thao, quý vị phải yêu cầu một người cung cấp dịch vụ y tế có thẩm quyền hoàn tất một mẫu đơn cho uống thuốc và/hay điều trị cho mỗi loại thuốc và hay điều trị cần được thi hành. Những mẫu đơn này có thể lấy tại trường học con quý vị hay trên mạng của Các Trường Công Lập Quận Montgomery (MCPS) tại [www.montgomeryschoolsmd.org](http://www.montgomeryschoolsmd.org): MCPS Form 525-12, Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement/Giấy cho phép cung cấp điều trị y khoa được chỉ định, Thỏa Thuận về Giải Trừ Trách Nhiệm và Bồi Hoàn, MCPS Form 525-13, Authorization to Administer Prescribed Medication, Release and Indemnification Agreement/Giấy cho phép uống thuốc như được chỉ định, Thỏa Thuận về Giải Trừ Trách Nhiệm và Bồi Hoàn, MCPS Form 525-14, Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector/Chăm Sóc Khẩn Cấp cho Học Sinh với Phản Ứng Quá Mẫn Tính. Nếu quý vị không có một người cung cấp dịch vụ y tế có thẩm quyền hay nếu con quý vị cần một quy trình y tế cá nhân đặc biệt, xin hãy liên lạc với hiệu trưởng và/hay y tá tại trường học con quý vị.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### 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): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

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  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. 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.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
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), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (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 <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. 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?		
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?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
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: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
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 <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> 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

**■ PREPARTICIPATION PHYSICAL EVALUATION**

**ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

**Explain "Yes" answers here.**

\_\_\_\_\_

\_\_\_\_\_

**Please indicate whether you have ever had any of the following conditions:**

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

**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: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_