



1/8

Dear Parents:

Campbell Clinic is again pleased to be able to offer pre-participation medical screenings for the 2024-2025 school year. The physicals will be held at our **Germantown office location on the first two (2) Saturdays during the month of June**. This will be June 1st, and June 8th from **8:00am until 11:00am**. The location is **1400 Germantown Road Germantown, TN 38138**

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, and weight.

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
ogolden@campbellclinic.com

John Hyden, M.D.
Medical Director for Physicals

2/8

**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, Text, 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 BARTLETT 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, 2025. 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

 Name Sex Age DOB

BARTLETT HIGH SCHOOL ^{Sport(s)}
School

Sport(s)

School

Telephone

Have you every had a preparticipation physical before? ____ Yes ____ No If yes, when/where _____

No

1. Have you ever been hospitalized?
Have you ever had surgery?
2. Are you presently taking any medications or pills?
3. Do you have allergies (medicine, bees or other stinging insects)?
4. Have you ever passed out during exercise?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain/discomfort during exercise?
Have you had excessive, unexpected or unexplained shortness of breath during exercise?
Do you tire more quickly than your friends during exercise?
Have you ever had high blood pressure?
Have you ever been told that you have a heart murmur?
Has anyone in your family died of heart problems or a sudden death before the age of 50?
Has anyone in your family developed a disability from heart disease before the age of 50?
5. Do you have any skin problems (itching, rashes, acne)?
6. Have you ever had a head injury?
Have you ever been knocked unconscious?
Have you ever had a seizure?
Have you ever had a stinger, burner or pinched nerve?
7. Have you ever had heat or muscle cramps?
Have you ever been dizzy or passed out in the heat?
8. Do you have trouble breathing or do you cough during or after activities?
9. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)?
10. Have you had any problems with your eyes or vision?
Do you wear glasses or contacts or protective eye wear?
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?
_____ Head _____ Shoulder _____ Thigh _____ Neck _____ Elbow
_____ Knee _____ Chest _____ Forearm _____ Shin/Calf _____ Foot
_____ Back _____ Wrist _____ Ankle _____ Hip _____ Hand
12. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?
13. Have you ever had a medical problem since your last evaluation?
14. Have you lost/gained more than 15 lbs over the last 6 months?
15. When was your last tetanus shot?
When was your last measles shot?
16. When was your first menstrual period?
When was your last menstrual period?
When was the longest time between your periods last year?

I hereby state that, to the best of my knowledge, my answers to the above questions are correct, and with my signature give Campbell Clinic permission to perform pre-participation physical on my child.

Date _____

Bartlett High School

School

EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school or it's representative, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION**EMERGENCY CONTACT INFORMATION**

Name: _____ Sport: _____ Sex: M _____ F _____

Grade: ²⁴⁻²⁵ _____ Age: _____ Date of Birth: ____/____/____

Parent's Name: _____

Father's SS#: _____ Mother's SS#: _____

Work Address: _____

Phone Number: _____

Home Address: _____

Phone Number: _____

Another Person to Contact: _____

Relationship: _____ Phone Number: _____

Insurance Name: _____

Policy and Group Numbers: _____

ALLERGIES: _____

Consent Statement: Authorizing Treatment

Parent's Signature: _____

Student's Signature (if over age 18): _____

II. PARENT'S CONSENT FOR ATHLETIC PARTICIPATION

I hereby give my consent for _____ to represent

(Name of Student)

BARTLETT HIGH SCHOOL in the sport of _____

(Name of School)

Date: _____ Signature: _____

III. TO PARENT/GUARDIAN:

Due to new laws regarding release and disclosure of medical records, including pre-participation physicals, we are now required to obtain written authorization from you to release this information to your child's school/coaches. This information may be used strictly for determining medical clearance to participate for athletic purposes only. Please sign and date below:

I _____ parent/guardian of _____ authorize Campbell Clinic to release pre-participation physical to Bartlett High School and their coaches for athletic participation for the 2024-2025 school year.

Signature_____
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



Campbell Clinic*

SPORTS MEDICINE

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 lability

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

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

General Physical Examination

8/8

Name _____ School Bartlett High School Grade 24-25
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: _____