DHS

FREE SPORTS PHYSICALS for 2025-2026 School Year

We are offering FREE sports physicals on Wednesday, **May 7, 2025** for current 9-11 grades. To be eligible the student must have a previous physical on file. This physical will be conducted during school hours here at DHS. Below is the information on how the physical process will work. Please read all details carefully and sign. If this form and physical packet is not completed, signed, and returned to DHS by April 28th, your child will not be eligible to participate.

Each student will have height, weight, vision and blood pressure completed. After that each student will move to the examination room with the provider. A healthcare provider from West Tennessee Healthcare, West Tennessee Bone and Joint, and/or Star Physical Therapy will be performing the physical. Please refer to the Physical Examination Form for a breakdown of the body systems that will be examined.

Student Name: _____ DOB: _____

Guardian Name: _____ Phone#: _____

*****I have read and understand what is involved in a sports physical examination. I hereby give my informed consent for my child to be interviewed and examined by the health care provider and his/her staff.**

Guardian signature: _____ Date: _____

If you have any questions, please contact
Hannah (731) 286-3630 or Tara at (731) 286-3625.

Safe Stars Parents/Guardians Code of Conduct

1. I understand and endorse the purpose of this department/organization: *Insert department/organization purpose statement here.*
2. I acknowledge that the experiences that my child has in youth sports will deeply inform their character, identity, and worldview for years to come. As a parent/guardian, I can use this experience to deepen our relationship or to severely damage it.
3. I acknowledge that coaching is hard work and being a great mentor-coach is even harder. I will support the coaches in the mission to use this sport to develop my child into their best self on and off the field.
4. I will applaud behavior in my child and his teammates that demonstrate healthy characteristics of integrity, empathy, sacrifice, and responsibility. I will not only affirm athletic performance or victory.
5. I assume my position as a role model for my child and his teammates, talking politely and acting courteously toward coaches, officials, other parents, and spectators.
6. I will show good sportsmanship by applauding the efforts of the other team members and our opponents.
7. I will accept defeat and disappointment graciously, knowing my child learns more in these moments that in triumph.
8. I will support the team regardless of how much my child plays or what the win-loss record is.
9. I will not hurt my child and embarrass myself by berating and shaming my child over a game. If my child hears my voice in games or practice it will be to encourage and build up.
10. If I have a disagreement with a coach, official, fan, or another adult, I will choose to address that issue at another time where kids are not present and everyone has had a chance to cool off.
11. I will let the coaches coach and the officials officiate. I recognize that neither job is easy and they are trying to do their best just like I am.
12. If I have concerns about how a coach or another adult is treating my child, I will have a conversation with that person first and then report it to the proper leadership if it does not resolve itself.

Because I am a parent with the power and platform to make a positive difference in the life of every player, I commit to this code of conduct. When failing to live up to these standards, I will allow for accountability and take responsibility for my actions.

Name of Parent/Guardian(s) Signature(s) Date

*Based on work from *InsideOut Coaching: How Sports Can Transform Lives* by. Joe Ehrmann and compiled by the Nashville Coaching Coalition (nashvillecoachingcoalition.com)

25-26

CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name _____ First Name _____ MI _____

Sex: [ ] Male [ ] Female Grade _____ Age _____ DOB ____/____/____

Allergies _____

Medications _____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

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 _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for **(athlete's name)** _____ to represent **(name of school)** Dyersburg High School in athletics realizing that such activity involves 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 **Signature of Parent/Guardian** **Date**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Student Athlete)

I, _____, authorize the disclosure of my protected health information ("PHI"), as described herein. I understand this authorization is voluntary and confirms my instructions regarding disclosure of my PHI. I understand that subsequent disclosures by person(s) or organization(s) authorized to receive my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

1. I authorize the following person and/or organization *to disclose* my PHI, by oral communications or in written format, to the person and/or organization as specified below in Paragraph No. 2.
   Name(s) Professional licensed staff members (PTs, OTs, ATCs)
   Organization(s) STAR Physical Therapy, LP
   Address _____

2. I authorize the following person and/or organization *to receive* my PHI, as disclosed by the person and/or organization listed above in Paragraph No. 1.
   Name(s) Athletic Department Staff Members
   Organization(s) Dyersburg City Schools
   Address _____

3. I authorize the person or organization specified in Paragraph No. 1. to disclose my PHI maintained by such person or organization. This includes my permission to release my records to, and discuss my medical/health conditions with, the person or organization listed in Paragraph No. 2.

4. The purpose for disclosure is for my health, safety and wellness and to facilitate communications regarding my ability to participate in the organization's athletic program.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person and/or organization named above may have already taken action in reliance on this authorization.

6. I understand that the person or organization specified in Paragraph No. 1 may not condition treatment on whether I sign this authorization.

7. This authorization expires one hundred eighty (180) days after my enrollment terminates at the organization listed above in Paragraph No. 2.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my instructions, and that a photocopy of this form is valid as the original to allow release/disclosure of my records and PHI.

_____ _____
Signature of Athlete Date

_____ _____
(Parent/Legal Guardian if Athlete is a Minor) Witness

Name(s) _____ D.O.B.

Address: _____

Telephone: _____

Student-athlete & Parent/Legal Guardian Concussion Statement

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

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

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.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	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 Student-Athlete Date

_____ _____

Signature of Parent/Legal guardian Date

TN Education

TN Health

Sudden Cardiac Arrest
Symptoms and Warning Signs

What is Sudden Cardiac Arrest (SCA)?

SCA is a life-threatening emergency that occurs when the heart suddenly and unexpectedly stops beating. This causes blood and oxygen to stop flowing to the rest of the body. The individual will not have a pulse. It can happen without warning and can lead to death within minutes if the person does not receive immediate help. Only 1 in 10 survives SCA. If Cardiopulmonary Resuscitation (CPR) is given and an Automatic External Defibrillator (AED) is administered early, **5 in 10** could survive.

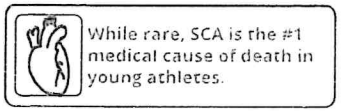
SCA is NOT a heart attack, which is caused by reduced or blocked blood flow to the heart. However, a heart attack can increase the risk for SCA.

Watch for Warning Signs

SCA usually happens without warning. SCA can happen in young people who don't know they have a heart problem, and it may be the first sign of a heart problem. When there are warning signs, the person may experience:

If any of these warning signs are present, it's important to talk with a health care provider. There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops due to SCA, blood stops flowing to the brain and other body organs. Death or permanent brain damage can occur in minutes.

Electrocardiogram (EKG) Testing



EKG is a noninvasive, quick, and painless test that looks at the heart's electrical activity. Small electrodes attached to the skin of the arms, legs, and chest capture the heartbeat as it moves through the heart. An EKG can detect some heart problems that may lead to an increased risk of SCA. Routine EKG testing is not currently recommended by national medical organizations, such as the American Academy of Pediatrics and the American College of Cardiology, unless the pre-participation physical exam reveals an indication for this test. The student or parent may request, from the student's health care provider, an EKG be administered in addition to the student's pre-participation physical exam, at a cost to be incurred by the student or the student's parent.

Limitations of EKG Testing

- An EKG may be expensive and cannot detect all conditions that predispose an individual to SCA.

TN Education

TN Health

- False positives (abnormalities identified during EKG testing that turn out to have no medical significance) may lead to unnecessary stress, additional testing, and unnecessary restriction from athletic participation.
- Accurate EKG interpretation requires adequate training.

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

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This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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 (M or F): _____

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 ≥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	**Unsure**	**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, 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 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? Unsure		
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?		

MENSTRUAL QUESTIONS	N/A	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: _____

adaptive from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. May 2023

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • 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 • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] 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

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: _____

_____

_____