Dustin Burton

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Pre-Participation Exam

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name _____ Male ☐ Female ☐ Grade _____ Date of Birth _____

Home Address _____ Phone Number _____

Parent's Name _____ Family Physician _____

Current School _____ Date _____

Explain "Yes" answers below. Circle questions to which you don't know the answer.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Are you taking medicine for ADHD?	☐	☐
5. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (circle all that apply): High blood pressure, A heart murmur, High cholesterol, A heart infection		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below:	☐	☐
19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

21. Have you ever had a stress fracture?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you ever had a head injury or concussion?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any problems with your eyes or vision?	☐	☐
41. Do you wear glasses or contact lenses?	☐	☐
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43. Are you happy with your weight?	☐	☐
44. Are you trying to gain or lose weight?	☐	☐
45. Have anyone recommended you change your weight or eating habits?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

COVID-19 ADDENDUM

48. Have you ever been diagnosed with or suspected you had COVID-19? If yes, did you have 4 or more days of fever (greater than 100.4°F), and/or 1 or more week of myalgia, chills, or lethargy?	☐ ☐	☐ ☐
49. Have you ever been hospitalized due to COVID-19 or diagnosed with MIS-C?	☐	☐

FEMALES ONLY

50. Have you ever had a menstrual period?	☐	☐
51. How old were you when you had your first menstrual period?	____	
52. How many periods have you had in the last year?	____	

Explain "Yes" answers here:

_____

_____

_____

Allergies: _____

Required for School† and Recommended Immunizations: (please check if student is up to date): ☐ Hepatitis A ☐ Hepatitis B ☐ Human Papillomavirus (HPV)

CLEARANCE

_____ _____

Typed or printed name of Student — Signature of Student

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports _____ Reason: _____

Recommendations: _____

_____

_____

Name of physician/medical provider [print or type] _____ Date _____

Address _____ Phone _____

Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

_____ _____

Typed or printed name of parent or guardian — Signature of parent or guardian

_____ _____ _____

Date — Address — Insurance (Company name)

_____ _____ _____ _____

Parent's Home Phone — Parent's Work Phone — Parent's Cell Phone — Additional Phone (if any-specify)

ALL INFORMATION IS TO REMAIN CONFIDENTIAL (Updated 4/21)

Emergency Action Plan (EAP)

- Understanding roles
- AHCT
  - MD
  - ATC/LAT
  - ATS
  - EMS
  - Coaches
  - School Administrators
  - School Nurses
  - School Counselors

Role of First Responder

Role of the First Responders

1. Activate the emergency medical system (EMS)
    a. DIAL 9-1-1 from cell phone or land line
    b. Provide relevant information to EMS such as:
        i. Responders name
        ii. Number of patients injured
        iii. Sex
        iv. Age
        v. Description of the emergency
        vi. Level of consciousness
        vii. Breathing/Circulation
        viii. Care initiated thus far
        ix. Phone number of person calling 911
        x. Address of venue
        xi. Specific directions to venue and designated access point
        xii. Other information requested by dispatcher
    c. Responder will meet or designate another individual to meet EMS at designated access point and direct to scene

Heat Illness

- Heat Syncope
  - Dehydration, fatigue, dizziness, light-headedness
- Heat Exhaustion
  - Inability to continue exercise, similar symptoms as Syncope, sweating profusely, pale skin, rapid pulse
- Heat Stroke
  - Central nervous system dysfunction, elevated core temp. (≥104°F), rapid HR, low BP, disoriented, possibly unconscious
  - This is medical emergency and body needs rapid cooling

TACO Technique

Treatment option 2: Tarp Assisted Cooling with Oscillation (TACO)

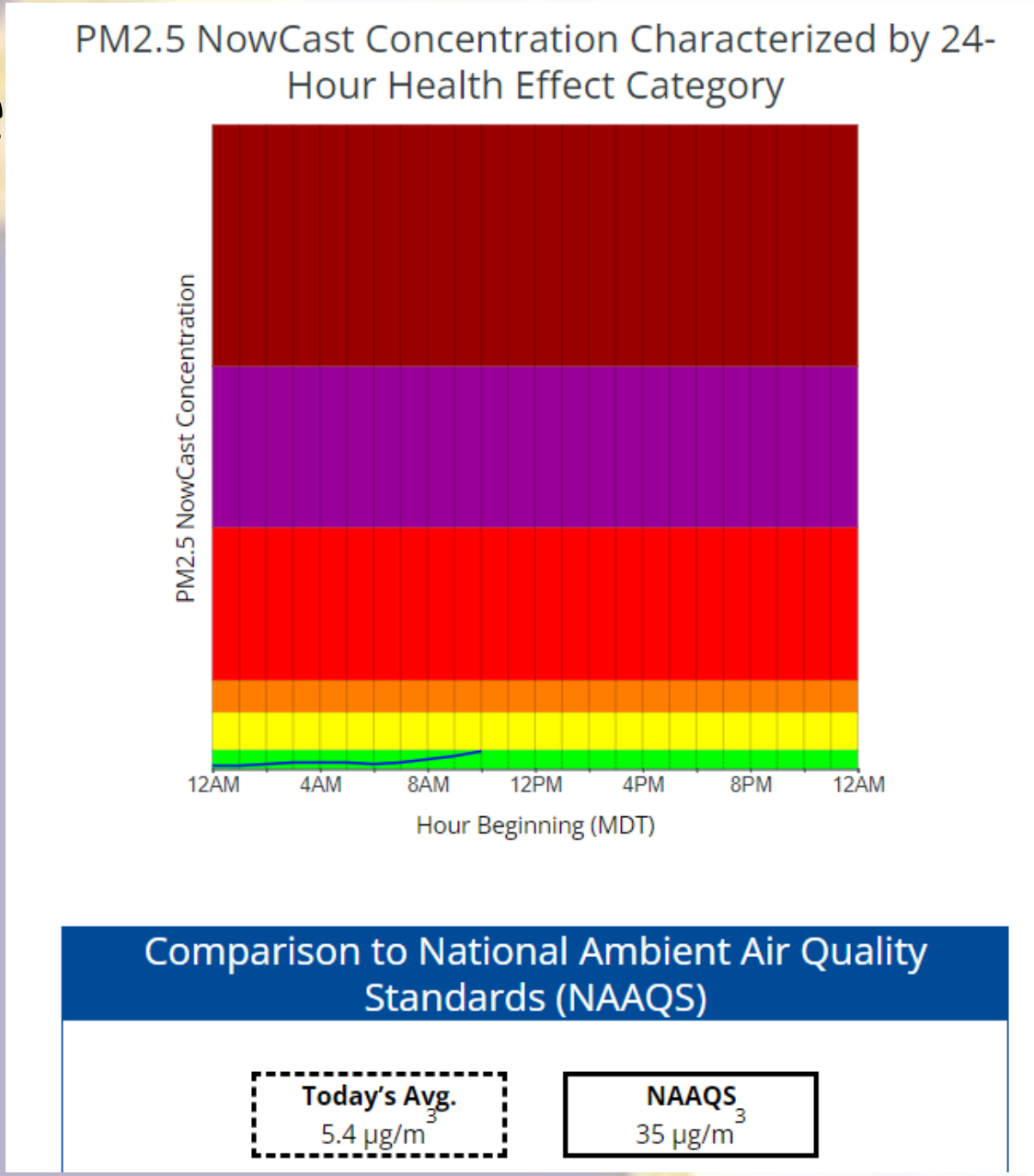
1. Place patient in center of tarp
2. Add ice and water to tarp
3. Holding onto each of the 4 corners of the tarp, oscillate the patient within the tarp
4. Once cooled, remove from tarp
5. Arrange for transport to medical facility while monitoring ABC's

Lightning Safety

- Lightning-detection devices or mobile phone apps can be used in accordance with NFHS and MHSA guidelines
- Suspend activity if lightning strike is noted within 10 miles of practice/event location
  - At least 30 minutes from last thunder/lightning

Air Quality – Wildfire Smoke

- Monitoring via Missoula County Department of Health and/or mt.gov website
  - Updates every hour



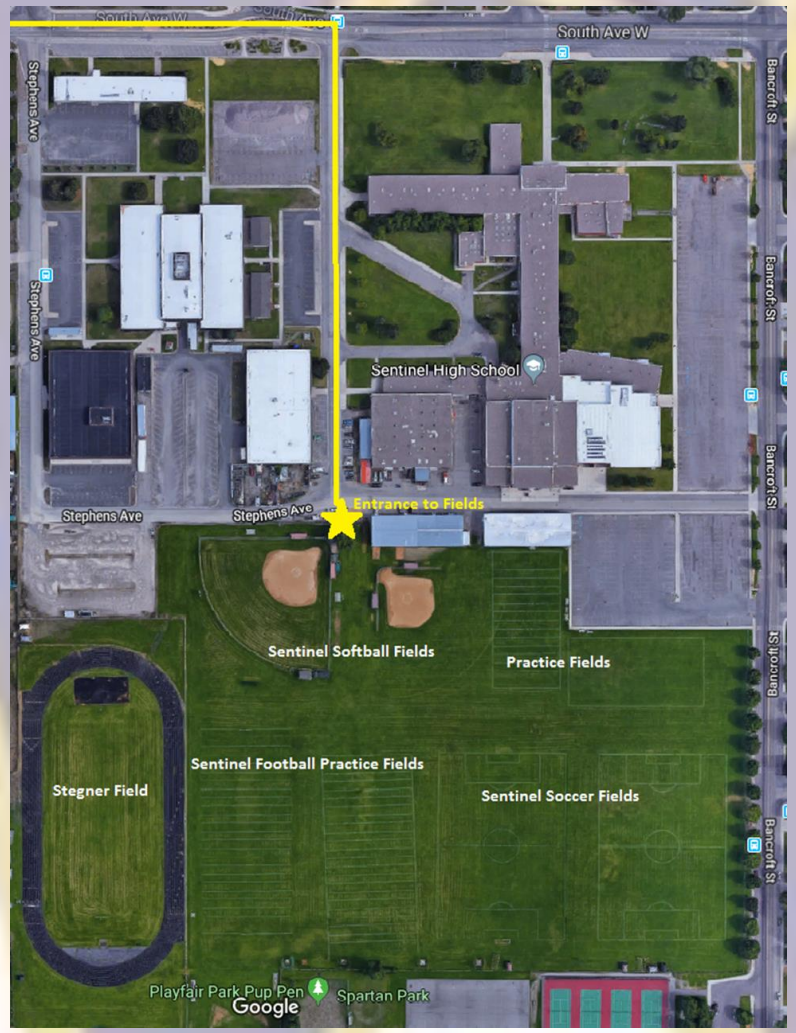
Air Quality - Visibility

Air Quality (Visibility Range)	Health Effects/Action Taken
Good (13 miles and up)	None. No action needed.
Moderate (9 to 13 miles)	Possible aggravation of heart and lung disease. **Monitor sensitive groups and limit their vigorous activity.**
Unhealthy for Sensitive Groups (5 to 9 miles)	Increasing likelihood of symptoms in sensitive individuals, aggravation of heart or lung disease and premature death in persons with cardiopulmonary disease, smokers and the elderly. **Increase rest periods and substitutions and limit vigorous activities.**
Unhealthy (2.25 to 5 miles)	Increased aggravation of heart or lung disease and premature death in persons with cardiopulmonary disease, smokers and the elderly; increased respiratory effects in general population. **Conduct practice and trainings indoors. Limit time spent outdoors and heavy or prolonged exertion. Increase rest breaks and substitutions. Consider rescheduling or relocating**
Very Unhealthy/Hazardous (1.25 to 2 miles)	Significant aggravation of heart or lung disease and premature death in persons with cardiopulmonary disease, smokers, and the elderly; significant increase in respiratory effects in general population. **Conduct practice or training in safe indoor environment. Reschedule or relocate event.**

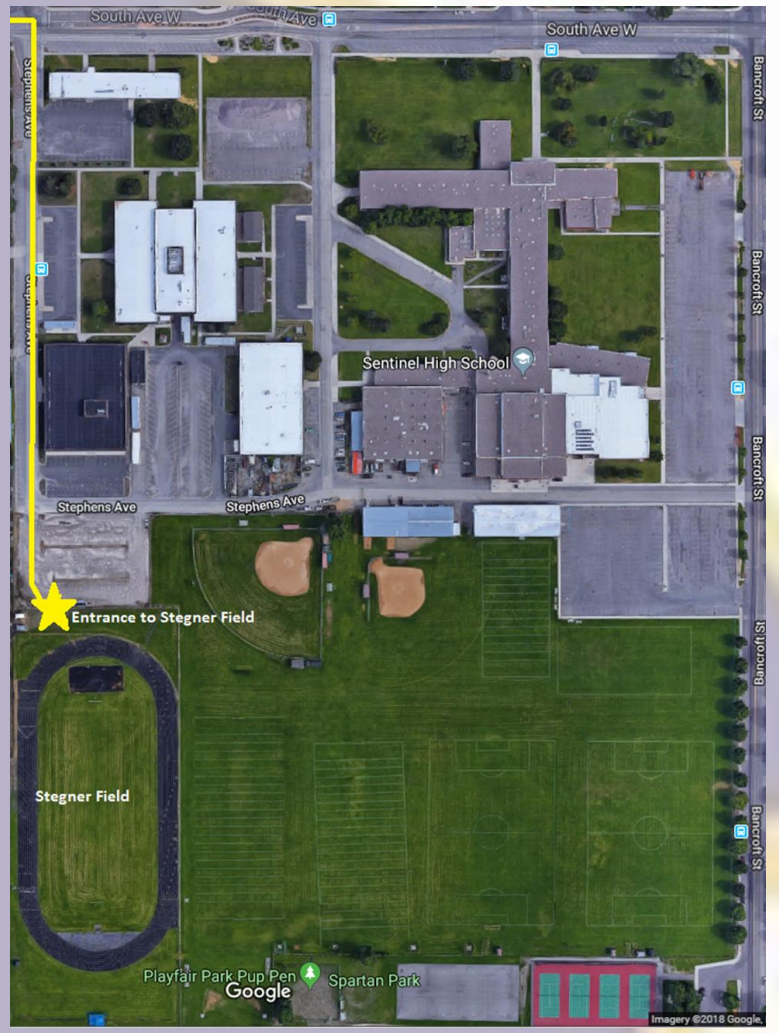
Recommendations for Outdoor Activities Based on Air Quality for Schools and Child Care Facilities

Health Effect Category	Good	Moderate	Unhealthy for sensitive groups*	Unhealthy	Very Unhealthy/ Hazardous
Visibility (miles)	13+	9-13	5-9	2-5	Less than 2
NowCast Concentration ($\mu g/m^3$)	≤ 12	12 - 35	35 - 55	55 - 150	150 +
Recess or Other Outdoor Activity (15 minutes)	No limitations	No limitations	Make indoor space available for all children to be active, especially young children. If outdoors, limit vigorous activities and people with chronic conditions should be medically managing their condition.	Keep all children indoors.	Keep all children indoors.
Physical Education Class (1 hour)	No limitations	Monitor sensitive groups and limit their vigorous activities.	Make indoor space available for all children to be active, especially young children. If outdoors, limit vigorous activities and people with chronic conditions should be medically managing their condition.	Conduct P.E. indoors. If outdoors, only allow light activities for all participants. People with chronic conditions should be medically managing their condition.	Conduct P.E. in a safe (good air quality) indoor environment.
Athletic Practice, Training (2-4 hours)	No limitations	Monitor sensitive groups and limit their vigorous activities.	People with chronic conditions should be medically managing their condition. Increase rest periods and substitutions for all participants to lower breathing rates.	Conduct practice and trainings indoors. If outdoors, allow only light activities for all participants. Add rest breaks or substitutions to lower breathing rates. People with chronic conditions should be medically managing their condition.	Conduct practice and trainings in a safe (good air quality) indoor environment.
Scheduled Sporting Events (2-4 hours)	No limitations	Monitor sensitive groups and limit their vigorous activities.	People with chronic conditions should be medically managing their condition. Increase rest periods and substitutions for all participants to lower breathing rates.	Consider rescheduling or relocating event. If outdoor event is held, have emergency medical support immediately available. Add rest breaks or substitutions to lower breathing rates. People with chronic conditions should be medically managing their condition.	Reschedule or relocate event.
Examples of light activities: Walking slowly on level ground Carrying school books Hanging out with friends			Examples of moderate activities: Skateboarding Slow pitch softball Shooting basketballs	Examples of vigorous activities: Running, jogging Playing football, soccer, and basketball	Please note that the intensity of an activity can vary by person and ability

Sentinel Fields



Stegner Field



Sentinel Indoor Facilities