



DragonFly MAX is an electronic health record designed to save you time & ensure the athlete is healthy and ready to participate in athletic competition. We focus on the details so you can focus on what matters...safe and healthy athletes.

Follow the easy steps below to get started using DragonFly MAX.

### "I'M A PARENT"

1. Visit [www.dragonflymax.com](http://www.dragonflymax.com), click "Do My Forms" and follow prompts to the sign-up page.
2. On the sign-up page, click "Sign Up for Free".
3. Follow the prompts to create your **Parent Account** with **your** email address or phone number.
4. Enter your child's School Code when prompted and confirm this is the correct school.
5. Click "Add A Child" in the DragonFly MAX web site, then follow the prompts to create your **child's profile** and complete his/her participation forms, including uploading any necessary documents.
6. After completing your child's forms, you can review his/her profile OR add another child's profile.

*Now that you're done, download DragonFly MAX from the App Store or Google Play and sign in.*

### "I'M AN ATHLETE, COACH, OR SCHOOL ADMINISTRATOR."

1. Download the DragonFly MAX app from either the App Store or Google Play.



2. Click "Get Started" and follow the prompts to create your account.
3. Choose your role in the school (i.e. - Athlete, Coach, Administrator, etc).
  - If you are a Coach or Administrator, select whether your school IS or IS NOT already using MAX.  
(Hint: If you have a School Code, then your school IS using MAX)
4. Enter your School Code (shown below) when prompted, then tap "Request" to join the school.

School Name: North Oconee High School  
School Code: 7HFJ3R

Now you're all set! You can find out more about additional features at  
[DRAGONFLYMAX.COM](http://DRAGONFLYMAX.COM)



## NORTH OCONEE HIGH SCHOOL ATHLETICS

1081 Rocky Branch Road, Bogart, Ga. 30622

Michael Dowis, Athletic Director

(706) 769-7760

### **PLEASE READ BEFORE COMPLETING THE FOLLOWING DOCUMENTS.**

The next two pages are the history forms, which should be completed on DragonFly MAX. If you completed the history form online and printed it out to take to the doctor, you do not have to complete the history form on the next two pages. History forms are available in Spanish upon request from the NOHS Athletic Office or on the GHSA website. Once completed, please upload ALL documents signed by the physician.

**Do not detach this page from this packet until after the student-athlete has been seen by the doctor.**

### **DragonFly MAX Tips:**

1. When creating the account or signing any documents, it is best to use a computer instead of a tablet/smartphone.
2. Complete the history form on DragonFly MAX and print. Take this document with you along with a blank physical form to the student-athlete's doctor's appointment. A doctor must have a completed history form in order to proceed.
3. If possible, scan the physical examination form and the clearance form together instead of taking pictures of each individual form when uploading. This allows the entire document to be uploaded as one.

### **Contact Information for any questions, concerns, or issues uploading documents:**

- Catherine Colquitt (Certified Athletic Trainer)
  - (706) 769-7760 ext 7306
  - ccolquitt@oconeeschools.org
- Tina Paul (Athletic Administrative Assistant)
  - (706) 769-7760 ext 2221
  - tpaul@oconeeschools.org

## ■ PREPARTICIPATION PHYSICAL EVALUATION

pg 3 of 7

effective 8/1/19–3/31/20

### 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 (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

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? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS		Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25.	Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY		Yes	No
29.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
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.**

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. A small portion of a yellowed piece of paper is visible at the top edge. The paper appears to be from a notebook or a set of loose-leaf papers.

**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>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
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>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
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>	<input type="checkbox"/>	

<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

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

## ■ 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: \_\_\_\_\_