BULLARD ATHLETICS

Athletic Information Packet

In order to compete in Bullard High Athletics, you must complete the following:

1. Register on Family ID for the 2021-2022 school year. Be sure to select ALL sports that you will be playing. Link below, or QR code below

https://www.familyid.com/bullard-high-school/2021-2022-athletic-registration-18

2. Proof of Insurance must be provided on Family ID

3.Sports Physical must be completed and dated after May 1, 2021 by an MD or DO and submitted to the Bullard Main Office

4. Physical must be stamped by the office where you obtained the physical

5. You must answer all health history questions on the form provided and submitted WITH physical

Student Name: ______________________

Fall Sport: _________________

Winter Sport: ___________________

Spring Sport: ___________________

A step-by-step guide to enrolling in quality health coverage

We've got you covered.

Covered California is where Californians can shop for and compare quality health plans among a variety of brand-name insurance companies. You may even get help paying for it.

This guide will help you better understand your coverage options so you can enroll in the health plan that best fits your needs.

We're here to help.

Covered California offers free, local, in-person enrollment help, online chat, and telephone assistance in 13 languages as well as for the hearing-impaired. For help at any point during the enrollment process, call **800.300.1506** or visit **CoveredCA.com**.

Step one:

See if you qualify for help paying for health coverage

Based on your annual household income, you may qualify for what's called an Advanced Premium Tax Credit (APTC) to help reduce your monthly premiums. Or you may qualify for low or no-cost coverage through Medi-Cal.

Coverage Year 2021

	Maximum Annual Household Income to Qualify for Financial Help	
FAMILY SIZE	**MEDI-CAL**	**COVERED CALIFORNIA**
1	$17,609	$76,560
2	$23,792	$103,440
3	$29,974	$130,320
4	$36,156	$157,200
5	$42,339	$184,080
6	$48,521	$210,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies. Medi-Cal enrollment is year-round.

Sign up Nov. 1 – Jan. 31 | **To be covered by Jan. 1 enroll by Dec. 15**

Una guía paso a paso para obtener cobertura de salud de calidad

Tenemos el plan para ti.

Covered California es el lugar donde los californianos pueden buscar y comparar planes de salud de calidad entre una variedad de compañías de seguros de renombre. Hasta podrías obtener ayuda para pagarlo.

Esta guía te ayudará a entender mejor tus opciones de cobertura para que puedas inscribirte en el plan de salud que mejor se ajusta a tus necesidades.

Estamos aquí para ayudarte.

Covered California ofrece ayuda gratis y confidencial en persona, chat en línea y ayuda telefónica en 13 idiomas como también para las personas con discapacidad auditiva. Para obtener ayuda en cualquier momento del proceso de inscripción, llama al **800.300.0213** o visita **CoveredCA.com/espanol**.

Paso uno:

Entérate si calificas para recibir ayuda económica para pagar tu seguro médico

Según tu ingreso familiar anual, es posible que califiques para lo que se llama un Crédito Fiscal Anticipado para la Prima (APTC, por sus siglas en inglés) para ayudarte a reducir tus primas mensuales. O, podrías calificar para obtener cobertura médica a bajo o ningún costo a través de Medi-Cal.

Año de cobertura 2021

	Ingreso familiar anual máximo para calificar para ayuda económica	
TAMAÑO FAMILIAR	**MEDI-CAL**	**COVERED CALIFORNIA**
1	$17,609	$76,560
2	$23,792	$103,440
3	$29,974	$130,320
4	$36,156	$157,200
5	$42,339	$184,080
6	$48,521	$210,960
	Podrías calificar para Medi-Cal a bajo o sin costo alguno.	*Podrías calificar para ayuda económica a través de Covered California.*

Las cantidades mostradas son solo estimaciones. Para familias más grandes, visita la herramienta de Buscar y Comparar en CoveredCA.com/espanol para saber si tu familia califica. La inscripción en Medi-Cal es todo el año.

Inscríbete el 1 de noviembre al 31 de enero.
Para que tu cobertura empiece el 1 de enero, inscríbete antes del 15 de diciembre.

List of Suggested Fresno Sports Physicals Locations

FOR 2021-2022 SCHOOL YEAR:

Parents must accompany student during appointment
Download sports physical packet BEFORE meeting with providers
Bring Medi-Cal and/or other insurance cards to physical appointment
*****FACE MASK required*****

Clinica Sierra Vista Managed School Based Health Centers

Location:	Gaston Middle School	Addams Elementary School
Address:	1120 E. Church Ave, Fresno, CA, 93706	1510 Lafayette Ave, Fresno, CA, 93728
Hours of Service:	**Monday-Friday** - 7:30-4pm **(Appointment only)**	**Monday-Friday** – 7:30-4pm **(Appointment only)**
Cost:	$15 for non-Clinica Sierra Vista patients	$15 for non-Clinica Sierra Vista patients
Licensed HealthCare Provider:	Kalila Banks, PA-C	Lisa Chapa, FNP
For Appointments:	(559) 457-6970 **Must state it is for a Sports Physical Only 1 parent/guardian allowed**	(559) 457-6860 **Must state it is for a Sports Physical Only 1 parent/guardian allowed**

Other Fresno Area providers

Location:	Family HealthCare Network
Address:	290 N. Wayte Ln, Fresno, CA 93701
Hours of Service:	**Monday thru Friday** - 8am-5pm
Cost:	Free - with insurance $20-$50 – without insurance on sliding fee scale
Licensed HealthCare Provider:	Dr. Raj Dhah, DO
For Appointments:	(559) 608-6500
Location:	**Saint Agnes Care Orthopaedic Institution (Ortho on Demand walk-in clinic)**
Address:	1510 E. Herndon Ave., Fresno, CA 93720, Suite 230
Hours of Service:	**Monday thru Friday** - 8am-4pm
Cost:	$25 – Cash only, **no appointment needed**
Licensed HealthCare Provider:	Dr. Richard Oravec, MD
Office Number:	(559) 450-2663

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): ______________

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? (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	**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 *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?		
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.

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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: ______________________________

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■ PREPARTICIPATION PHYSICAL EVALUATION

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		
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

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PREPARTICIPATION PHYSICAL EVALUATION
MEDICAL ELIGIBILITY FORM

Name:_______________________ Date:_________ Student Id:_____________

Sport(s) requesting clearance for:____

HT________ WT_______ BMI%_______Vision __________Corrected ☐ Y ☐ N Hgb_________

___

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ____

____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations:

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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) listed on this form. If conditions arise after the athlete has been cleared for participation, the practitioner may rescind the medical eligibility until the problem is resolved.

Name of practitioner (print): ______________________________Date:_________________

Address: _____________________________________ Phone:_____________________________

Signature of practitioner:____________________________, MD, DO, NP, or PA

EMERGENCY INFORMATION

Allergies: ____

Medications: ____

____

Pertinent health information: ____

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