



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

Instructions for completing your child's Athletic Participation Form:

1. Go to www.dragonflymax.com, click "LOG IN/SIGN UP" to begin creating your account.
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, then verify your account.
4. Enter your student's School Code (JL3CX4) when prompted and confirm it is Eastside High School.
5. Now click on "Add a Child" in DragonFly Max, then follow the prompts to create your child's profile. To complete his/her participation forms, select "Submit Paperwork". Next, scroll down to "Things to Do" and select "Get Started." Here you will electronically sign and upload any necessary documents such as Insurance Card and Medical Physical
6. Take the copy of the attached Athletic Paperwork Packet to your physician. After your physician completes the forms, upload them to your child's profile (instructions to help with uploading documents are included). If your physician wants to view your medical history you can print it from DragonFly and take it with you.
7. After completing all forms, you can review your child's profile OR add another child.

**** YOUR CHILD IS NOT ELIGIBLE TO CONDITION, TRYOUT, PRACTICE OR COMPETE IN ANY SPORT UNTIL 100% COMPLETION IS REACHED IN HIS/HER PROFILE.****

Now that you're done, on your phone, download DragonFly MAX from the APP Store or Google Play and sign in.



SCHOOL NAME: EASTSIDE HIGH SCHOOL
SCHOOL CODE: JL3CX4

INSTRUCTIONS FOR UPLOADING YOUR CHILD'S PHYSICAL EXAMINATION AND MEDICAL ELIGIBILITY CLEARANCE FORMS

You can either upload the form online while logged into your DragonFly account on your computer or through the DragonFly app using your cell phone's camera.

ONLINE USING A COMPUTER:

- Scan your completed physical form using a scanner and save it on your computer using a unique file name.
- While logged into DragonFly, scroll down to the "Things to Do" and select "Get Started." Uploads cannot be submitted until "*Update Medical & Demographic Info*" is complete.
- Select "Start" next to *PPE Physical Examination & Clearance Form*. Then choose "*Upload The Document.*"
- Choose the date you completed your physical by selecting the appropriate month, day, and year from the drop down menu.
- Click "Drag + drop here" to open the browser on your computer to find your physical file to upload.
- Click "Upload" for your physical form to upload.
- You will get a "Pending Approval" notice once your file is uploaded.

Administrators at the school will be notified once files are uploaded and will check physical for completion before approving. Once approved, the athlete will be cleared for this requirement.

USING DRAGONFLY APP ON YOUR CELL PHONE (CAMERA):

- Log into your account and select "tap here to complete school's paperwork"
- Select *PPE Physical Examination & Clearance Form*.
- Select "*Upload The Document.*"
- Choose the date you completed your physical by selecting the appropriate month, day, and year from the drop down menu.
- Click "Drag + drop here/click to browse."
- Select "Take Photo" to access camera to take picture of physical form or select "Photo Library" if you want to upload a picture of the physical that has already been made.
- Click "Upload" for your physical form to upload.
- You will get a "Pending Approval" notice once your photo is uploaded.

***Parents will keep original of their child's completed physical form. No paper work will be turned in to the Eastside Athletic Department.

**Follow similar prompts to upload an image of your Insurance Card for approval.*

■ 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: _____

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	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?		

■ 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"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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: _____

