

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic*, to the effect that the student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

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

Home Address _____ Phone # _____

Parent's/Guardian's Name _____ Date _____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. *A parent or guardian is required to sign on the other side of this form.*)

- | Yes | No | Has this student had any? | Yes | No | Has this student had any? |
|-----------|-------|---|-----------|-------|--|
| 1. _____ | _____ | Chronic or recurrent illness or injury? | 16. _____ | _____ | Asthma? |
| 2. _____ | _____ | Any illness lasting more than one (1) week? | 17. _____ | _____ | Epilepsy or other seizures? |
| 3. _____ | _____ | Rheumatic fever, mononucleosis? | 18. _____ | _____ | Diabetes? |
| 4. _____ | _____ | Hospitalizations (Overnight or longer)? | 19. _____ | _____ | Eyeglasses or contact lenses? |
| 5. _____ | _____ | Surgery, other than tonsillectomy? | 20. _____ | _____ | Dental braces, bridges, plates? |
| 6. _____ | _____ | Missing organs (eye, kidney, testicle)? | | | |
| 7. _____ | _____ | Allergy to medications, insects, food? | | | |
| 8. _____ | _____ | Seasonal allergies (hay fever)? | | | |
| 9. _____ | _____ | Problems with heart, blood pressure, cholesterol? | 21. _____ | _____ | Injuries requiring medical treatment? |
| 10. _____ | _____ | Racing of your heart or skipped heart beats? | 22. _____ | _____ | Neck injury? |
| 11. _____ | _____ | Chest pain with exercise? | 23. _____ | _____ | Knee injury? |
| 12. _____ | _____ | Frequent headaches, convulsions, dizziness, fainting? | 24. _____ | _____ | Knee surgery? |
| 13. _____ | _____ | Dizziness or fainting with exercise? | 25. _____ | _____ | Ankle injury? |
| 14. _____ | _____ | Concussion, unconsciousness, extremity numbness? | 26. _____ | _____ | Broken bones (fractures)? |
| 15. _____ | _____ | Heat exhaustion, heat stroke, or other heat related problems? | 27. _____ | _____ | Other serious joint injuries? |
| | | | 28. _____ | _____ | Use of protective equipment or braces? |

- | Yes | No | Further History: |
|-----------|-------|---|
| 29. _____ | _____ | Is there a history of family or genetic disease? |
| 30. _____ | _____ | Has any family member died suddenly at less than 40 years of age of causes other than an accident? |
| 31. _____ | _____ | Has any family member had a heart attack at less than 55 years of age? |
| 32. _____ | _____ | Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping? |

Use this space to explain any of the above numbered YES answers or to provide additional information:

33. List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A. _____ B. _____ C. _____

34. Year of last known: Tetanus (lockjaw) vaccination: _____ Meningitis vaccination: _____ HBV vaccination: _____

35. What is the most and least you have weighed in the past year? **Most** _____ **Least** _____

FOR WOMEN ONLY:

- How old were you when you had your first menstrual period? _____
- In the past year, what is the longest time you have gone between menstrual periods? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1). *This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for regular health maintenance examinations.*

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____ / _____ Vision R 20/ _____ L 20/ _____ Vision corrected? Yes _____ No _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Mouth & Teeth			
4. Neck			
5. Lymph Nodes			
6. Heart (Standing & Lying)			
7. Pulses (esp. femoral)			
8. Chest & Lungs			
9. Abdomen			
10. Skin			
11. Genitals - Hernia			
12. Musculoskeletal - ROM, strength, etc. (See questions 21-28)			
13. Neurological			

Comments regarding abnormal findings: _____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

FULL & UNLIMITED PARTICIPATION

LIMITED PARTICIPATION - May NOT participate in the following (checked):

- Baseball Basketball Cross Country Football Golf Soccer
 Softball Swimming Tennis Track Volleyball Wrestling

CLEARANCE PENDING DOCUMENTED FOLLOW UP OF _____

NOT CLEARED FOR ATHLETIC PARTICIPATION

Licensed Medical Professional's Name (Printed) _____ Date _____

Licensed Medical Professional's Signature _____ Phone _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also **give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

Typed or printed Name of Parent or Guardian _____ Signature of Parent of Guardian _____

Address (Street/PO Box, City, State, Zip) _____ Phone Number _____