

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 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 back of this form after the physical examination is completed.*)

<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Yes</td> <td style="width: 10%;">No</td> <td style="width: 80%;">Has this student had any?</td> </tr> <tr> <td>1. _____</td> <td>_____</td> <td>Chronic or recurrent illness or injury?</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>Any illness lasting more than one (1) week?</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>Rheumatic fever, mononucleosis?</td> </tr> <tr> <td>4. _____</td> <td>_____</td> <td>Hospitalizations (Overnight or longer)?</td> </tr> <tr> <td>5. _____</td> <td>_____</td> <td>Surgery, other than tonsillectomy?</td> </tr> <tr> <td>6. _____</td> <td>_____</td> <td>Missing organs (eye, kidney, testicle)?</td> </tr> <tr> <td>7. _____</td> <td>_____</td> <td>Allergy to medications, insects, food?</td> </tr> <tr> <td>8. _____</td> <td>_____</td> <td>Seasonal allergies (hay fever)?</td> </tr> <tr> <td>9. _____</td> <td>_____</td> <td>Problems with heart, blood pressure, cholesterol?</td> </tr> <tr> <td>10. _____</td> <td>_____</td> <td>Racing of your heart or skipped heart beats?</td> </tr> <tr> <td>11. _____</td> <td>_____</td> <td>Chest pain with exercise?</td> </tr> <tr> <td>12. _____</td> <td>_____</td> <td>Frequent headaches, convulsions, dizziness, fainting?</td> </tr> <tr> <td>13. _____</td> <td>_____</td> <td>Dizziness or fainting with exercise?</td> </tr> <tr> <td>14. _____</td> <td>_____</td> <td>Concussion, unconsciousness, extremity numbness?</td> </tr> <tr> <td>15. _____</td> <td>_____</td> <td>Heat exhaustion, heat stroke, or other heat related problems?</td> </tr> </table>	Yes	No	Has this student had any?	1. _____	_____	Chronic or recurrent illness or injury?	2. _____	_____	Any illness lasting more than one (1) week?	3. _____	_____	Rheumatic fever, mononucleosis?	4. _____	_____	Hospitalizations (Overnight or longer)?	5. _____	_____	Surgery, other than tonsillectomy?	6. _____	_____	Missing organs (eye, kidney, testicle)?	7. _____	_____	Allergy to medications, insects, food?	8. _____	_____	Seasonal allergies (hay fever)?	9. _____	_____	Problems with heart, blood pressure, cholesterol?	10. _____	_____	Racing of your heart or skipped heart beats?	11. _____	_____	Chest pain with exercise?	12. _____	_____	Frequent headaches, convulsions, dizziness, fainting?	13. _____	_____	Dizziness or fainting with exercise?	14. _____	_____	Concussion, unconsciousness, extremity numbness?	15. _____	_____	Heat exhaustion, heat stroke, or other heat related problems?	<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Yes</td> <td style="width: 10%;">No</td> <td style="width: 80%;">Has this student had any?</td> </tr> <tr> <td>16. _____</td> <td>_____</td> <td>Asthma?</td> </tr> <tr> <td>17. _____</td> <td>_____</td> <td>Epilepsy or other seizures?</td> </tr> <tr> <td>18. _____</td> <td>_____</td> <td>Diabetes?</td> </tr> <tr> <td>19. _____</td> <td>_____</td> <td>Eyeglasses or contact lenses?</td> </tr> <tr> <td>20. _____</td> <td>_____</td> <td>Dental braces, bridges, plates?</td> </tr> </table> <table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">Yes</td> <td style="width: 10%;">No</td> <td style="width: 80%;">Is there a history of?</td> </tr> <tr> <td>21. _____</td> <td>_____</td> <td>Injuries requiring medical treatment?</td> </tr> <tr> <td>22. _____</td> <td>_____</td> <td>Neck injury?</td> </tr> <tr> <td>23. _____</td> <td>_____</td> <td>Knee injury?</td> </tr> <tr> <td>24. _____</td> <td>_____</td> <td>Knee surgery?</td> </tr> <tr> <td>25. _____</td> <td>_____</td> <td>Ankle injury?</td> </tr> <tr> <td>26. _____</td> <td>_____</td> <td>Broken bones (fractures)?</td> </tr> <tr> <td>27. _____</td> <td>_____</td> <td>Other serious joint injuries?</td> </tr> <tr> <td>28. _____</td> <td>_____</td> <td>Use of protective equipment or braces?</td> </tr> </table>	Yes	No	Has this student had any?	16. _____	_____	Asthma?	17. _____	_____	Epilepsy or other seizures?	18. _____	_____	Diabetes?	19. _____	_____	Eyeglasses or contact lenses?	20. _____	_____	Dental braces, bridges, plates?	Yes	No	Is there a history of?	21. _____	_____	Injuries requiring medical treatment?	22. _____	_____	Neck injury?	23. _____	_____	Knee injury?	24. _____	_____	Knee surgery?	25. _____	_____	Ankle injury?	26. _____	_____	Broken bones (fractures)?	27. _____	_____	Other serious joint injuries?	28. _____	_____	Use of protective equipment or braces?
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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?	
33. _____	_____	List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:	
	A.	B.	C.
34.	What is the most and least you have weighed in the past year? Most _____ Least _____		
35.	Year of last known: Tetanus (lockjaw) shot: _____ Meningitis vaccination: _____ HBV vaccination: _____		

FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period? _____

2. In the past year, what is the longest time you have gone between menstrual periods? _____

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

PHYSICAL EXAMINATION RECORD (To be completed by a licensed 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/_____

	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: _____

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 Professional's Name (Printed) **Date**

Licensed Professional's Signature **Phone**

Parent's or Guardian's Permission and Release (Sign after the physical examination has been completed.)

I hereby 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, 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