

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

- | 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? | | | |
| 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? | | | |

- | Yes | No | Further History: | Yes | No | Is there a history of? |
|-----------|-------|---|-----------|-------|--|
| 29. _____ | _____ | Is there a history of family or genetic disease? | 21. _____ | _____ | Injuries requiring medical treatment? |
| 30. _____ | _____ | Has any family member died suddenly at less than 40 years of age of causes other than an accident? | 22. _____ | _____ | Neck injury? |
| 31. _____ | _____ | Has any family member had a heart attack at less than 55 years of age? | 23. _____ | _____ | Knee injury? |
| 32. _____ | _____ | Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping? | 24. _____ | _____ | Knee surgery? |
| | | | 25. _____ | _____ | Ankle injury? |
| | | | 26. _____ | _____ | Broken bones (fractures)? |
| | | | 27. _____ | _____ | Other serious joint injuries? |
| | | | 28. _____ | _____ | Use of protective equipment or braces? |

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

35. Year of last known: Tetanus (lockjaw) vaccination: _____ 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? _____

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 Medical Professional's Name (Printed) _____ Date _____

 Licensed Medical 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 _____