

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Article VI 36.14(1) Physical Exam. Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon or osteopath, qualified chiropractor, physician's assistant, or advanced registered nurse practitioner to the effect that the student has been examined and may safely engage in athletic competition.

The certificate of physical examination is valid for the purpose of this rule for one calendar year. A grace period not to exceed thirty days is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please Print)

NAME _____ MALE _____ FEMALE _____ DATE OF BIRTH _____ GRADE _____

HOME ADDRESS _____ PHONE # _____

PARENT'S NAME _____ FAMILY PHYSICIAN _____

_____ Date _____ Signature of Student

HEALTH HISTORY (Student Athlete or Parent/Guardian to Fill Out #1 - 31 Before Exam) (Parent/Guardian is Required to Sign on Back of the Form After Examination.)

- | Yes | No | Has This Student Had Any? | Yes | No | Has This Student Had Any? |
|-----------|-------|---|------------|-----------|---------------------------------------|
| 1. _____ | _____ | Chronic or recurrent illness? | 14. _____ | _____ | Asthma? |
| 2. _____ | _____ | Hospitalizations? | 15. _____ | _____ | Epilepsy? |
| 3. _____ | _____ | Surgery, other than tonsillectomy? | 16. _____ | _____ | Diabetes? |
| 4. _____ | _____ | Missing organs (eye, kidney, testicle)? | 17. _____ | _____ | Eyeglasses or contact lenses? |
| 5. _____ | _____ | Allergy to medications? | 18. _____ | _____ | Dental braces, bridges, plates? |
| 6. _____ | _____ | Problems with heart or blood pressure? | | | |
| 7. _____ | _____ | Chest pain with exercise? | Yes | No | Is there a history of? |
| 8. _____ | _____ | Dizziness or fainting with exercise? | 19. _____ | _____ | Injuries requiring medical treatment? |
| 9. _____ | _____ | Frequent headaches, convulsions, dizziness or fainting? | 20. _____ | _____ | Neck injury? |
| 10. _____ | _____ | Concussion or unconsciousness? | 21. _____ | _____ | Knee injury? |
| 11. _____ | _____ | Heat exhaustion, heat stroke, or other heat problems? | 22. _____ | _____ | Knee surgery? |
| 12. _____ | _____ | Any illness lasting over a week? | 23. _____ | _____ | Ankle injury? |
| 13. _____ | _____ | Rheumatic fever? | 24. _____ | _____ | Other serious joint injury? |
| | | | 25. _____ | _____ | Broken bones (fractures)? |

- Yes No Further history:**
26. _____ Is there any history of family or genetic disease?
27. _____ Has any family member died suddenly at less than 40 years of age of causes other than an accident?
28. _____ Has any family member had a heart attack at less than 55 years of age?
29. _____ Are you uncomfortably short of breath after running 1/2 mile (2 times around the track) without stopping?
30. List all medications you are presently taking and what condition the medication is for.

A. _____
B. _____
C. _____

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

Date of last known tetanus (lockjaw) shot: _____

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 any additional information: /

PHYSICAL EXAMINATION RECORD (To Be Filled Out by Licensed Professional)

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____ Hemoglobin (Optional) _____ UA (Optional) _____

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose and Throat			
3. Mouth and Teeth			
4. Neck			
5. Cardiovascular			
6. Chest and Lungs			
7. Abdomen			
8. Skin			
9. Genitals-Hernia			
10. Musculoskeletal: ROM, strength, etc.			
11. Neurological			

Comments re Abnormal Findings: _____

Participation Recommendations

Full and 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 _____

No Athletic Participation

Licensed Professional's Name (Printed) _____

Date _____

Signature _____

Phone _____

Parent's or Guardian's Permission and Release

I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to give first aid treatment to this student at an athletic event in case of injury.

Typed or Printed Name of Parent or Guardian _____

Signature of Parent or Guardian _____

Address _____

Phone _____

Date _____