

**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 _____ Physician _____

Signature of Student Athlete _____ Date _____

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?	15. _____	_____	Asthma?
2. _____	_____	Any illness lasting more than one (1) week?	16. _____	_____	Epilepsy or other seizures?
3. _____	_____	Rheumatic fever, mononucleosis?	17. _____	_____	Diabetes?
4. _____	_____	Hospitalizations (Overnight or longer)?	18. _____	_____	Eyeglasses or contact lenses?
5. _____	_____	Surgery, other than tonsillectomy?	19. _____	_____	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?	20. _____	_____	Injuries requiring medical treatment?
11. _____	_____	Chest pain with exercise?	21. _____	_____	Neck injury?
12. _____	_____	Frequent headaches, convulsions, dizziness, fainting?	22. _____	_____	Knee injury?
13. _____	_____	Dizziness or fainting with exercise?	23. _____	_____	Knee surgery?
14. _____	_____	Concussion, unconsciousness, extremity numbness?	24. _____	_____	Ankle injury?
15. _____	_____	Heat exhaustion, heat stroke, or other heat related problems?	25. _____	_____	Broken bones (fractures)?
			26. _____	_____	Other serious joint injuries?
			27. _____	_____	Use of protective equipment or braces?

Yes No Further History:

28. _____ Is there a history of family or genetic disease?

29. _____ Has any family member died suddenly at less than 40 years of age of causes other than an accident?

30. _____ Has any family member had a heart attack at less than 55 years of age?

31. _____ Are you uncomfortably short of breath after running 1/2 mile (2 times around a track) without stopping?

32. _____ List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:
 A. _____
 B. _____
 C. _____

33. What is the most and 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 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/ _____ Hemoglobin (Opt) _____ UA (Opt) _____

	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)			
7. Chest & Lungs			
8. Abdomen			
9. Skin			
10. Genitals - Hernia			
11. Musculoskeletal - ROM, strength, etc. (See questions 20-27)			
12. 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 _____