IHSA Preparticipation Examination

To be completed by athlete or parent

Name ______________________________ Sport/Position ____________
Last First Middle

Social Security Number ____________________ School Year ____________

Address ____

City/State ____________________ Phone No. ____________

Birthdate ____________ Age ______ Class ______ Student ID No. ____________

Parent's Name ____

Address ____

Phone No. ____________

Person to contact in case of emergency ____________________

Phone No. ____________

Family Doctor ____________ City/State ____________

Phone No. ____________

Past Medical History

		Yes	No	If yes, please explain (what, where, when)
1.	Presently taking medication (including birth control pills)?			
2.	Have you been diagnosed with asthma?			
3.	Have you been prescribed by a physician to use any asthma medication?			
4.	Do you have a current consent form to self-administer the asthma medication on file with your school?			
5.	Allergic to medicine, foods, bee stings?			
6.	Wears any appliances—glasses, contact lenses?			
7.	History of braces, chipped teeth, bridges?			
8.	Has ongoing medical problem?			
9.	Had serious or significant illness in past?			
10.	Any past surgical operations, accidents, non-sports or related injuries?			
11.	Any past injuries directly related to sports?			
12.	Any hospitalization not explained above?			
13.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?			
14.	Any serious family illness (such as diabetes, bleeding disorders, etc.)?			
15.	Heart			
	Have you ever passed out during or after exercise?			
	Have you ever been dizzy during or after exercise?			
	Have you ever had chest pain during or after exercise?			
	Do you get tired more quickly than your friends do during exercise?			
	Have you ever had racing of your heart or skipped heartbeats?			
	Have you had high blood pressure or high cholesterol?			
	Have you ever been told you have a heart murmur?			
	Has any family member or relative died of heart problems or of sudden death before age 50?			
	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?			
	Has a physician ever denied or restricted your participation in sports for any heart problems?			
	Has anyone in your family had a heart attack before the age of 50?			
16.	Head and Nerve			
	Have you ever had a head injury or concussion?			
	Have you ever been knocked out, become unconscious, or lost your memory?			
	Have you ever had a seizure?			
	Do you have frequent or severe headaches?			
	Have you ever had numbness or tingling in your arms, hands, legs or feet?			
	Have you ever had a stinger, burner or pinched nerve?			
17.	Last tetnus shot?	Date		
18.	Last eye exam?	Date		
19.	Last menstrual period (if women)	Date		

Personal Habits

		Yes	No
1.	Smoking/smokeless tobacco		
2.	Alcohol/non-medical drugs: marijuana, cocaine, etc		
3.	Steroids		
4.	Eating Disorders – weight loss or gain?		

Review of systems (Please check if you have any problems with any of the following areas of your body)

____ Skin
____ Head
____ Eyes
____ Ears
____ Nose
____ Mouth/Throat
____ Nutrition, Weight Control
____ Neck
____ Lungs
____ Heart
____ Abdomen
____ Back
____ Urination, Bowel Control
____ Genital (including menstrual for women)
____ Shoulders, Arms, Hands
____ Hips, Legs, Feet
____ Muscles—Strength, Feeling
____ Mental, Emotional
____ Fatigue
____ Other. What? ____________

I certify that the above information is correct to the best of my knowledge.

Student Signature ________________________________

Parent/Guardian Signature ________________________________

Both Student And Parent/Guardian Signatures Are Mandatory

Physical Examination

Height __________ Weight __________ Blood Pressure __________

Pulse: resting __________ 15 hops __________ after 2 minutes __________

Visual Acuity: Eyes (R) 20/ ______ w/o glasses ______ (L) 20/ ______ w/ glasses ______

Other Testing	Normal	Abnormal Findings
1. General		
2. Skin		
3. HEENT		
4. Teeth (Dental Exam)		
5. Neck		
6. Lungs		
7. Heart (Sit and Stand)		
8. Abdomen		
9. Genitalia		
10. Musculoskeletal		
Neck		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Back		
Hip/Thigh		
Knee		
Shin/Calf		
Ankle/Leg		
Foot		
11. Peripheral Pulses		
12. Neurologic		
13. Mental Status		
14. Marfan Screen		

Other Tests (optional)

________ Auditory	________ U/A	________ EKG
________ % Body Fat	________ Drug Screen	________ Chest X-Ray
________ Hgb/Hct	________ SMAC	________ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes ________ No ________ Limited ________

Additional Comments:

Examination Date __________ Physicians Signature ______________________________

Physician's Assistant Signature* ______________________________

Advanced Nurse Practitioner Signature* ______________________________

* effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

STUDENT'S NAME ______________________________

SCHOOL NAME ______________________________

Consent Form to self administer asthma medication

(not needed if current form is already on file with school)

Parent Consent

I, ______________________, do hereby give my son/daughter, ______________________, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

______________________ Parent Signature ____________ Date

Physician Consent

As a patient under my care, ______________________, is prescribed to self-administer the following asthma medication.

Medication ______________________________

Purpose ______________________________

____

____

Dosage ______________________________

Time/Special Circumstances ______________________________

______________________________.

______________________ Physician Signature ____________ Date