## 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? |
|---|---|---|---|
| 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? |

| | 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? |

| | 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? |

***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 sub stitute 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

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. 7/06