ATHLETIC PRE-PARTICIPATION
PHYSICAL EXAMINATION

<u>ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.</u> 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 ______________________________ 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?*
15.	____	____	Asthma?
16.	____	____	Epilepsy or other seizures?
17.	____	____	Diabetes?
18.	____	____	Eyeglasses or contact lenses?
19.	____	____	Dental braces, bridges, plates?

	Yes	No	**Is there a history of?**
20.	____	____	Injuries requiring medical treatment?
21.	____	____	Neck injury?
22.	____	____	Knee injury?
23.	____	____	Knee surgery?
24.	____	____	Ankle injury?
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 ½ 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. <u>In the past year</u>, 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/_______

	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 20-27)*			
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 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

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. 8/00