ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Article VII 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?
1.	____	____	Chronic or recurrent illness?
2.	____	____	Hospitalizations?
3.	____	____	Surgery, other than tonsillectomy?
4.	____	____	Missing organs (eye, kidney, testicle)?
5.	____	____	Allergy to medications?
6.	____	____	Problems with heart or blood pressure?
7.	____	____	Chest pain with exercise?
8.	____	____	Dizziness or fainting with exercise?
9.	____	____	Frequent headaches, convulsions, dizziness or fainting?
10.	____	____	Concussion or unconsciousness?
11.	____	____	Heat exhaustion, heat stroke or other heat problems?
12.	____	____	Any illness lasting over a week?
13.	____	____	Rheumatic fever?

	Yes	No	Has This Student Had Any?
14.	____	____	Asthma?
15.	____	____	Epilepsy?
16.	____	____	Diabetes?
17.	____	____	Eyeglasses or contact lenses?
18.	____	____	Dental braces, bridges, plates?
	Yes	**No**	**Is there a History of?**
19.	____	____	Injuries requiring medical treatment?
20.	____	____	Neck injury?
21.	____	____	Knee injury?
22.	____	____	Knee surgery?
23.	____	____	Ankle injury?
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 ½ 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 of Guardian

_____ _____ _____
Address Phone Date

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.