Please fill out this entire form

IOWA 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)

STUDENT NAME:	FEMALE ___ MALE ___	DATE OF BIRTH (MM/DD/YYYY)	
HOME ADDRESS:		CITY:	ZIP:
SCHOOL DISTRICT:		GRADE:	DATE:
PARENT/GUARDIAN NAME:			
HOME PHONE:	CELL PHONE:		
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 other side of this form after the examination.

	YES	NO	DOES THIS STUDENT HAVE/EVER HAD?
1.			Allergies to medication, pollen, stinging insects, food, etc.
2.			Any illness lasting more than one (1) week?
3.			Asthma or difficulty breathing during exercise?
4.			Chronic or recurrent illness or injury?
5.			Diabetes?
6.			Epilepsy or other seizures?
7.			Eyeglasses or contacts?
8.			Herpes or MRSA?
9.			Hospitalizations (Overnight or longer)?
10.			Marfan Syndrome?
11.			Missing organ (eye, kidney, and testicle)?
12.			Mononucleosis or Rheumatic fever?
13.			Seizures or frequent headaches?
14.			Surgery?
15.			Chest pressure, pain, or tightness with exercise?
16.			Excessive shortness of breath with exercise?
17.			Headaches, dizziness or fainting during, or after, exercise?

	YES	NO	DOES THIS STUDENT HAVE/EVER HAD?
18.			Heart problems (Racing skipped beats, murmur, infection, etc.?)
19.			High blood pressure or high cholesterol?
20.			Head injury, concussion, unconsciousness?
21.			Headache, memory loss, or confusion with contact?
22.			Numbness, tingling or weakness in arms or legs with contact?
23.			Severe muscle cramps or illness when exercising in the heat?
24.			Fracture, stress fracture or dislocated joint(s)?
25.			Injuries requiring medical treatment?
26.			Knee injury or surgery?
27.			Neck injury?
28.			Orthotics, braces, protective equipment?
29.			Other serious joint injury?
30.			Painful bulge or hernia in the groin area?
31.			X-rays, MRI, CT scan, physical therapy?
32.			**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.			**Do you have any concerns you would like to discuss with your health care provider?**

	YES	NO	FAMILY HISTORY
34.			Does anyone in your family have Marfan Syndrome?
35.			Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.			Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.			Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.			Does anyone in your family have asthma?
39.			Do you or someone in your family have sickle cell trait or disease?
			Use this space to explain any **"YES"** answers from above (questions #1-38) or to **provide any additional information.**

40. Are you allergic to any prescription or over-the-counter medications? If yes, please list. _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A._____ B._____ C._____

42. Year of last known vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? Most_____ Least_____

44. Are you happy with your current weight? Yes ___ No ___ **If no,** how many pounds would you like to lose or gain? _____

FOR FEMALES ONLY
How old were you when you had your first menstrual periods?
How many periods have you had in the last 12 months?

PARENT/GUARDIAN MUST SIGN AT BOTTOM AFTER THIS FORM HAS BEEN COMPLETED BY A MEDICAL PROFESSIONAL

PHYSICAL EXAMINATION RECORD

To be completed by a licensed medical 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: _____ / _____ (Repeat, if abnormal _____ / _____)	Vision: R 20 / _____	L 20 / _____

		NORMAL	ABNORMAL FINDINGS	INITIALS
1.	Appearance (esp. Marfan's)			
2.	Eyes/Ears/Nose/Throat			
3.	Pupil Size (Equal/Unequal)			
4.	Mouth/Teeth			
5.	Neck			
6.	Lymph Nodes			
7.	Heart (Standing & Lying)			
8.	Pulses (especially femoral)			
9.	Chest & Lungs			
10.	Abdomen			
11.	Skin			
12.	Genitals – Hernia			
13.	Musculoskeletal – ROM, strength, etc. (see questions 24-31)			
14.	Neurological			

Comments regarding abnormal findings: _____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL AND UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** – May **NOT** participate in the following (checked):

____ Baseball ____ Basketball ____ Bowling ____ Cross Country ____ Football ____ Golf ____ Soccer

____ Softball ____ Swimming ____ Tennis ____ Track ____ Volleyball ____ Wrestling

_____ **CLEARANCE PENDING** – Document Follow-up to _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION** Due to _____

_____ _____

Licensed Medical Professional's Name (Printed) **Date of PPE**

_____ _____

Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **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, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

_____ _____

Name of Parent or Guardian (Printed) **Signature of Parent or 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. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. 9/12