

**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 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.** )

- | <b>Yes</b> | <b>No</b> | <b>Has this student had any?</b>                              | <b>Yes</b> | <b>No</b> | <b>Has this student had any?</b> |
|------------|-----------|---|------------|-----------|----------------------------------|
| 1. _____   | _____     | Chronic or recurrent illness or injury?                       | 16. _____  | _____     | Asthma?                          |
| 2. _____   | _____     | Any illness lasting more than one (1) week?                   | 17. _____  | _____     | Epilepsy or other seizures?      |
| 3. _____   | _____     | Rheumatic fever, mononucleosis?                               | 18. _____  | _____     | Diabetes?                        |
| 4. _____   | _____     | Hospitalizations (Overnight or longer)?                       | 19. _____  | _____     | Eyeglasses or contact lenses?    |
| 5. _____   | _____     | Surgery, other than tonsillectomy?                            | 20. _____  | _____     | Dental braces, bridges, plates?  |
| 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? |            |           |                                  |

- | <b>Yes</b> | <b>No</b> | <b>Further History:</b>  | <b>Yes</b> | <b>No</b> | <b>Is there a history of?</b>         |  |
|------------|-----------|--|------------|-----------|---------------------------------------|--|
| 29. _____  | _____     | Is there a history of family or genetic disease?   | 21. _____  | _____     | Injuries requiring medical treatment? |  |
| 30. _____  | _____     | Has any family member died suddenly at less than 40 years of age of causes other than an accident?                 | 22. _____  | _____     | Neck injury?                          |  |
| 31. _____  | _____     | Has any family member had a heart attack at less than 55 years of age?   | 23. _____  | _____     | Knee injury?                          |  |
| 32. _____  | _____     | Are you uncomfortably short of breath after running 1/2 mile (2 times around a track) without stopping?            | 24. _____  | _____     | Knee surgery?                         |  |
| 33. _____  | _____     | List all medications you are presently taking, including asthma inhalers, and the condition the medication is for: | 25. _____  | _____     | Ankle injury?                         |  |
|            |           | A. _____   |            |           | 26. _____                             | Broken bones (fractures)?              |
|            |           | B. _____   |            |           | 27. _____                             | Other serious joint injuries?          |
|            |           | C. _____   |            |           | 28. _____                             | Use of protective equipment or braces? |
| 34. _____  | _____     | What is the most and least you have weighed in the past year? Most _____ Least _____                               |            |           |                                       |  |
| 35. _____  | _____     | Year of last known: Tetanus (lockjaw) shot: _____ 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? \_\_\_\_\_

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/ \_\_\_\_\_

	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS</b>
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 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**