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 other side of this form.)***

	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. Year of last known: Tetanus (lockjaw) vaccination: _____ Meningitis vaccination: _____ HBV vaccination: _____

35. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least*** _____

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 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 _____/_____ Vision R 20/_____ L 20/_____ Vision corrected? Yes_____ No_____

	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: _____

LICENSED MEDICAL PROFESSIONAL'S 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

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.

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. 7/07