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's 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 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, testicle)?
12.	_____	_____	Mononucleosis or Rheumatic fever?
13.	_____	_____	Seizures or frequent headaches?
14.	_____	_____	Surgery?

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	Yes	*No*	*Does this student have / ever had?*
15.	_____	_____	Chest pressure, pain, or tightness with exercise?
16.	_____	_____	Excessive shortness of breath with exercise?
17.	_____	_____	Headaches, dizziness or fainting during, or after, exercise?
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?

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	Yes	*No*	*Does this student have / ever had?*
23.	_____	_____	Severe muscle cramps or illness when exercising in the heat?

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	Yes	*No*	*Does this student have / ever had?*
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?

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	Yes	*No*	*Does this student have / ever had?*
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:*
31.	_____	_____	Does anyone in your family have Marfan syndrome?
32.	_____	_____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
33.	_____	_____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
34.	_____	_____	Has anyone in your family had unexplained fainting, seizures, or near drowning?
35.	_____	_____	Does anyone your family have asthma?

*Use this space to explain any **"YES"** answers from above (questions #1-35) or **to provide any additional information**:*

____

____

____

34. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* ______________________________
35. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. ______________________________ B. ______________________________ C. ______________________________
36. Year of last known: Tetanus (lockjaw) vaccination: ___________ Meningitis vaccination: ___________
37. What is the most and least you have weighed in the past year? ***Most*** _________________ ***Least*** ____________________
38. Are you happy with your current weight? ***Yes*** _____ ***No*** _____ ***If no***, how many pounds would you like to lose or gain?
Lose _____ *Gain* _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? ____________________

2. How many periods have you had in the last 12 months? _______________________

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 (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. *(See questions 23-27)*			
14. 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 _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** ______________________

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** ______________________

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.

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

ACTIVITIES PARTICIPATION FORM

We, the undersigned parents of _____________________, do hereby consent to his/her participation in all selected high school activities elected: Athletic, Forensic Activities, Publications, Instrumental Music, Vocal Music, Clubs and Organizations, Academic Activities.

_________________________ ____________________________________

Date Signature of Parent/Guardian

ATHLETIC INSURANCE WAIVER

We do hereby certify that __________________ is covered by an insurance policy which protects him/her against an injury incurred while participating in the interscholastic activities program of the Denison Community School District.

_________________________ ____________________________________

Date Signature of Parent/Guardian

GOOD CONDUCT RULE APPROVAL

We hereby acknowledge that we have read the attached activities rules and regulations and agree to adhere to the regulations to the best of our ability while participating in activities for the Denison Community Schools.

_________________________ ____________________________________

Date Signature of Parent/Guardian

____

Signature of Student

LOST & STOLEN EQUIPMENT

I understand that my child will be asked to pay the cost of school equipment lost or stolen while in his/her care.

_________________________ ____________________________________

Date Signature of Parent/Guardian

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Signature of Student

EMERGENCY MEDICAL AUTHORIZATION

Student Name ____________________________Address_____________________________Birth date___________

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I--TO GRANT CONSENT

In the event reasonable attempts to contact me at _______________(phone) or ____________ (other parent/guardian) at _____________(phone) have been unsuccessful, I hereby give my consent for (1) the admission of any treatment deemed necessary by Dr. _____________(family physician) or Dr. _______________ (preferred dentist) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the student to the local hospital.

_________________________ ____________________________________

Date Signature of Parent/Guardian

*****DO NOT COMPLETE PART II, IF YOU COMPLETED PART I*****

PART II--NOT TO GRANT CONSENT

I do not give my consent for emergency medical treatment of my child.

_________________________ ____________________________________

Date Signature of Parent/Guardian