

# 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?		Yes	No	Has This Student Had Any?
1.	_____	_____	Chronic or recurrent illness?	14.	_____	_____	Asthma?
2.	_____	_____	Hospitalizations?	15.	_____	_____	Epilepsy?
3.	_____	_____	Surgery, other than tonsillectomy?	16.	_____	_____	Diabetes?
4.	_____	_____	Missing organs (eye, kidney, testicle)?	17.	_____	_____	Eyeglasses or contact lenses?
5.	_____	_____	Allergy to medications?	18.	_____	_____	Dental braces, bridges, plates?
6.	_____	_____	Problems with heart or blood pressure?				
7.	_____	_____	Chest pain with exercise?		<b>Yes</b>	<b>No</b>	<b>Is there a History of?</b>
8.	_____	_____	Dizziness or fainting with exercise?	19.	_____	_____	Injuries requiring medical treatment?
9.	_____	_____	Frequent headaches, convulsions, dizziness or fainting?	20.	_____	_____	Neck injury?
10.	_____	_____	Concussion or unconsciousness?	21.	_____	_____	Knee injury?
11.	_____	_____	Heat exhaustion, heat stroke or other heat problems?	22.	_____	_____	Knee surgery?
12.	_____	_____	Any illness lasting over a week?	23.	_____	_____	Ankle injury?
13.	_____	_____	Rheumatic fever?	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 1/2 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