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.

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 1/2 miles (2 times around a track) without stopping?
33. . ____	_____	List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A. B. C.

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 your 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 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/Ears/Nose/Throat			
2. Mouth and Teeth			
3. Neck			
4. Lymph Nodes			
5. Heart			
6. Pulses			
7. Chest & Lungs			
8. Abdomen			
9. Skin			
10. Genitals - Hernia			
11. Muscoskeletal			
12. 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 Professionals Signature **Phone**

Parent's or Guardian's Permission and Release
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

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.