Griswold Community Schools Athletic Pre-Participation Physical Exam form - grades 6th - 12th

form on-line www.griswoldschools.org

Article VII 36.14(1) Physical Exam. Every year each student (grades 6-12) 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 chiropractor, 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 (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 PRINT)

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 AFTER the physical examination is completed.***

	Yes	No	Has This Student Had Any.....
1.	___	___	Chronic or recurrent illness?
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 or blood pressure, cholesterol?
10.	___	___	Racing of your heart or skipped heart beats?
11.	___	___	Chest pain with exercise?
12.	___	___	Frequent headaches, convulsions, dizziness, or fainting?
13.	___	___	Dizziness or fainting with exercise?
14.	___	___	Concussion, unconsciousness, extremity numbness?
15.	___	___	Heat exhaustion, heat stroke, or other heat problems?
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?

Further History:

	Yes	No	
29.	___	___	Is there any 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 mile (2 times around the track) without stopping?

33. List all medications you are presently taking and what condition the medication is for:
A. _____ B. _____ C. _____
34. What is the most and the 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 any additional information:

_____

Physical Examination Record - (To be completed by a licensed professional as designed in Article VII 36.14 (1).

This evaluation is only to be determined 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 R20/_____ L20/ _____

	Normal	Abnormal Findings	Initials
1. Appearance (esp. Marfan's)			
2. Ears, Nose, and Throat			
3. Mouth and Teeth			
4. Neck			
5. Lymph Nodes			
6. Heart (standing & lying)			
7. Pulses (esp. femoral)			
8. Chest and Lungs			
9. Abdomen			
10. Skin			
11. Genitals - Hernia			
12. Musculoskeletal: ROM (strength, etc) (see questions 21-28)			
13. Neurological			

Comments regarding 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 _____

____ NOT CLEARED FOR ATHLETIC PARTICIPATION

Licensed Medical Professional's Name (printed) _____ Date _____

Licensed Medical Professional's Signature _____ Date _____

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 or Guardian

Address: _____

Phone _____ Date: _____

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 Girl's High School Athletic Union.