

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 | <i>Has this student ever had?</i> |
|-----------|-------|--|
| 1. _____ | _____ | Chronic or recurrent illness or injury? |
| 2. _____ | _____ | Any illness lasting more than one (1) week? |
| 3. _____ | _____ | Mononucleosis or Rheumatic fever? |
| 4. _____ | _____ | Hospitalizations (Overnight or longer)? |
| 5. _____ | _____ | Surgery, other than tonsillectomy? |
| 7. _____ | _____ | Allergies to pollen, stinging insects, food, etc.? |
| 8. _____ | _____ | High blood pressure or high cholesterol? |
| 9. _____ | _____ | Heart problems (Racing, murmur, skipped beats, infection, etc.?) |
| 10. _____ | _____ | Chest pressure or pain with exercise? |
| 11. _____ | _____ | Dizziness or fainting with exercise? |
| 12. _____ | _____ | Excessive shortness of breath with exercise? |
| 13. _____ | _____ | Seizures or frequent headaches? |
| 14. _____ | _____ | Head injury, concussion, unconsciousness? |
| 15. _____ | _____ | Numbness, tingling or weakness in arms or legs with contact? |
| 16. _____ | _____ | Headache, memory loss, or confusion with contact? |
| 17. _____ | _____ | Severe muscle cramps or become ill when exercising in the heat? |

- | Yes | No | <i>Has this student ever had?</i> |
|-----------|-------|-----------------------------------|
| 18. _____ | _____ | Asthma? |
| 19. _____ | _____ | Epilepsy, or other seizures? |
| 20. _____ | _____ | Diabetes? |
| 21. _____ | _____ | Herpes infection? |
| 22. _____ | _____ | Marfan Syndrome? |
| 23. _____ | _____ | Eyeglasses or contact lenses? |

- | Yes | No | <i>Is there a history of?</i> |
|-----------|-------|--|
| 24. _____ | _____ | Injuries requiring medical treatment? |
| 25. _____ | _____ | Neck injury? |
| 26. _____ | _____ | Knee injury or surgery? |
| 27. _____ | _____ | Other serious joint injuries? |
| 28. _____ | _____ | Use of protective equipment or braces? |

- *****
- | | | |
|-----------|-------|--|
| 29. _____ | _____ | Has a doctor ever denied or restricted your participation in sports for any reason? |
| 30. _____ | _____ | Do you have any concerns that you would like to discuss with your doctor? |

- | Yes | No | <i>Family History:</i> |
|-----------|-------|--|
| 31. _____ | _____ | Does anyone in your family have Marfan syndrome? |
| 32. _____ | _____ | Has anyone in your family died suddenly for no apparent reason? |
| 33. _____ | _____ | Has anyone in your family had a heart attack at less than 55 years of age? |

Use this space to explain any "YES" answers from above (questions #1-33) 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** _____

FOR FEMALES ONLY:

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

2. In the past 12 months, 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 _____ / _____ (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 26-30)			
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 _____