

## 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:

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**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

**INSURANCE RELEASE**

1. 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 understand that sports participation can involve many RISKS OF INJURY. I understand that dangers and risks of playing or practicing to play in athletics include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons and other aspects of the musculo-skeletal system and serious injury or impairment to other aspects of my child's body, general health and well-being.

2. I also give my permission for the team physician, athletic trainer or other qualified personnel to obtain medical attention for this student at an athletic event in case of injury or illness.

3. I also understand that all students of Johnston Community Schools are held accountable for their conduct by district policy. All students and parents should read the Code of Conduct and be aware of the policy's implication and enforcement.

4. **INSURANCE:** All participants in athletics must have some type of family health/accident insurance coverage or must purchase an alternate school policy. Persons not purchasing school insurance should understand that there is no school insurance to provide protection to their child during any phase of his/her participation in athletics. Insurance information is available in the Athletic Office.

A. \_\_\_\_\_ My child is covered by a family health/accident insurance

B. \_\_\_\_\_ I will purchase the alternate health/accident policy available through Johnston Community Schools in order to provide my child with insurance coverage.

\_\_\_\_\_  
 Parent or Guardian Date

\_\_\_\_\_  
 Student's signature Date