



Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name Last First Middle Sport/Position School Year

Address City/State Phone No.

Birthdate Age Class Phone No.

Parent's Name Address

Phone No. Person to contact in case of emergency

Phone No. Family Doctor City/State

Phone No. Past Medical History

Yes No If yes, please explain (what, where, when)

- 1. Presently taking medication (including birth control pills)?
2. Have you been diagnosed with asthma?
3. Have you been prescribed by a physician to use any asthma medication?
4. Do you have a current consent form to self-administer the asthma medication on file with your school?
5. Allergic to medicine, foods, bee stings?
6. Wears any appliances - glasses, contact lenses?
7. History of braces, chipped teeth, bridges?
8. Has ongoing medical problem?
9. Had serious or significant illness in past?
10. Any past surgical operations, accidents, non-sports or related injuries?
11. Any past injuries directly related to sports?
12. Any hospitalization not explained above?
13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?
14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?
15. Family history of cancer?
16. Heart
Have you ever passed out during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?

Yes No If yes, please explain (what, where, when)

- 17. Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden death before age 50?
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems?
Has anyone in your family had a heart attack before the age of 50?
Head and Nerve
Have you ever had a head injury or concussion?
Have you ever been knocked out, become unconscious, or lost your memory?
Have you ever had a seizure?
Do you have frequent or severe headaches?
Have you ever had numbness or tingling in your arms, hands, legs or feet?
Have you ever had a stinger, burner, or pinched nerve?
18. Last tetanus shot?
19. Last eye exam?
20. Last menstrual period (if women)

Personal Habits

- 1. Smoking/smokeless tobacco
2. Alcohol/non-medical drugs: marijuana, cocaine, etc.
3. Steroids
4. Eating Disorders - weight loss or gain?

Review of systems (Please check if you have any problems with any of the following areas of your body)

Table with 2 columns: System (Skin, Head, Eyes, Nose, Mouth/Throat, Nutrition, Weight Control, Neck, Lungs, Heart, Abdomen, Back, Urination, Bowel Control, Genital, menstrual for women) and Symptoms (Shoulders, Arms, Hands, Hips, Legs, Feet, Muscle-Strength, Feeling, Mental, Emotional, Fatigue, Other: What?)

I certify that the above information is correct to the best of my knowledge.

Student Signature

Parent/Guardian Signature

Both Student and Parent/Guardian Signatures Are Mandatory

Physical Examination

Height _____ Weight _____ Blood Pressure _____

Pulse: resting _____ 15 hops _____ after 2 minutes resting _____

Visual Acuity: Eyes (R) 20/____ w/o glasses _____ (L) 20/____ w/glasses _____

Other Testing _____ Normal _____ Abnormal Findings _____

1. General _____
2. Skin _____
3. HEENT _____
4. Teeth (Dental Exam) _____
5. Neck _____
6. Lungs _____
7. Heart (Sit and Stand) _____
8. Abdomen _____
9. Genitalia _____
10. Musculoskeletal _____
- Neck _____
- Shoulder/Arm _____
- Elbow/Forearm _____
- Wrist/Hand _____
- Back _____
- Hip/Thigh _____
- Knee _____
- Shin/Calf _____
- Ankle/Leg _____
- Foot _____
11. Peripheral Pulses _____
12. Neurologic _____
13. Mental Status _____
14. Marfan Screen _____

Other Tests (optional)
 Auditory _____ U/A _____
 % Body Fat _____ Drug Screen _____
 Hgb/Hct _____ SMAC _____
 _____ EKG _____
 _____ Chest X-Ray _____
 _____ Tanner Stage _____

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes _____ No _____ Limited _____

Additional Comments:

Examination Date _____ Physician's Signature _____

Physician's Assistant Signature* _____

Advanced Nurse Practitioner's Signature* _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

PARENT'S PERMISSION FOR ATHLETICS AND TRANSPORTATION

Understanding the aims and accomplishments of the Interscholastic program, I hereby give my child permission to participate in _____. Every precaution will be taken to insure your child's safety; however, we ask that every player carry school insurance or have the equivalent.

Also, participating in the athletic conference requires taking bus trips to other schools in the area and parental permission is requested for this purpose. Every precaution will be taken for the child's safety, but the teacher, driver, nor school can assume no responsibility in case of an accident.

- Please check one of the following:
- _____ We have school insurance.
 - _____ We have our own insurance.
 - _____ We have no insurance.

- Please check one of the following:
- _____ Yes, my child may participate in athletics and bus participation.
 - _____ I do not give my permission for athletics or transportation.

Signature of Parent or Guardian

Date