



## 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)

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 form after the physical examination is completed.)

- | Yes       | No    | <b>Has this student had any?</b>                              | Yes       | No    | <b>Has this student had any?</b> |
|-----------|-------|---|-----------|-------|----------------------------------|
| 1. _____  | _____ | Chronic or recurrent illness or injury?                       | 16. _____ | _____ | Asthma?                          |
| 2. _____  | _____ | Any illness lasting more than one (1) week?                   | 17. _____ | _____ | Epilepsy or other seizures?      |
| 3. _____  | _____ | Rheumatic fever, mononucleosis?                               | 18. _____ | _____ | Diabetes?                        |
| 4. _____  | _____ | Hospitalizations (Overnight or longer)?                       | 19. _____ | _____ | Eyeglasses or contact lenses?    |
| 5. _____  | _____ | Surgery, other than tonsillectomy?                            | 20. _____ | _____ | Dental braces, bridges, plates?  |
| 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    | <b>Further History:</b>   |
|-----------|-------|---|
| 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 ½ mile (2 times around a track) without stopping? |

**Use this space to explain any of the above numbered YES answers or to provide additional information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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) vaccination: \_\_\_\_\_ 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? \_\_\_\_\_

**PHYSICAL EXAMINATION RECORD** (To be completed by a licensed 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 \_\_\_\_\_ Vision R 20/\_\_\_\_ L 20/\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's )	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Mouth & Teeth	_____	_____	_____
4. Neck	_____	_____	_____
5. Lymph Nodes	_____	_____	_____
6. Heart (Standing & Lying)	_____	_____	_____
7. Pulses (esp. femoral)	_____	_____	_____
8. Chest & Lungs	_____	_____	_____
9. Abdomen	_____	_____	_____
10. Skin	_____	_____	_____
11. Genitals - Hernia	_____	_____	_____
12. Musculoskeletal - ROM, strength, etc. (See questions 21-28)	_____	_____	_____
13. 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 Medical Professional's Name (Printed) Date

\_\_\_\_\_  
 Licensed Medical Professional's Signature Phone

**Parent's or Guardian's Permission and Release** (Sign after the physical examination has been completed.)

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. 7/06

# HEADS UP: Concussion in High School Sports

**The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:**

- (1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
- (2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
- (3) Key definitions:
  - “**Licensed health care provider**” means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
  - “**Extracurricular interscholastic activity**” means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

## What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

## What parents/guardians should do if they think their child has a concussion?

1. **OBEY THE NEW LAW.**
  - a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
  - b. Seek medical attention right away.
2. Teach your child that it’s not smart to play with a concussion.
3. Tell all of your child’s coaches and the student’s school nurse about ANY concussion.

## What are the signs and symptoms of a concussion?

You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

## STUDENTS:

If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

**IT’S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.**

## Signs Reported by Students:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

## PARENTS:

### How can you help your child prevent a concussion?

Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches’ rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

## Signs Observed by Parents or Guardians:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.

For more information visit: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion)

Student’s Signature

Date

Student’s Printed Name

Parent’s/Guardian’s Signature

Date

Student’s School