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 print this information)

Name _____ Male ____ Female ____ Date of Birth _____ Grade _____

Home Address _____ School District _____

Parent/Guardian's Name _____ Date _____ Phone # _____

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	Does this student have/ever had?
1.	____	____	Allergies to medication, pollen, stinging insects, food, etc.?
2.	____	____	Any illness lasting more than one (1) week?
3.	____	____	Asthma or difficulty breathing during exercise?
4.	____	____	Chronic or recurrent illness or injury?
5.	____	____	Diabetes?
6.	____	____	Epilepsy or other seizures?
7.	____	____	Eyeglasses or contacts?
8.	____	____	Herpes or MRSA?
9.	____	____	Hospitalizations (overnight or longer)?
10.	____	____	Marfan Syndrome?
11.	____	____	Missing organ (eye, kidney, testicle)?
12.	____	____	Mononucleosis or Rheumatic fever?
13.	____	____	Seizures or frequent headaches?
14.	____	____	Surgery?
15.	____	____	Chest pressure, pain or tightness with exercise?
16.	____	____	Excessive shortness of breath with exercise?
17.	____	____	Headaches, dizziness or fainting during or after exercise?
18.	____	____	Heart problems (racing, skipped beats, murmur, infection, etc.)?
19.	____	____	High blood pressure or high cholesterol?
20.	____	____	Head injury, concussion, unconsciousness?
21.	____	____	Headache, memory loss, or confusion with contact?
22.	____	____	Numbness, tingling or weakness in arms or legs with contact?
23.	____	____	Severe muscle cramps or illness when exercising in the heat?
24.	____	____	Fracture, stress fracture or dislocated joint(s)?
25.	____	____	Injuries requiring medical treatment?
26.	____	____	Knee injury or surgery?
27.	____	____	Neck injury?
28.	____	____	Orthotics, braces, protective equipment?
29.	____	____	Other serious joint injury?
30.	____	____	Painful bulge or hernia in the groin area?
31.	____	____	X-rays, MRI, CT scan, physical therapy?
32.	____	____	**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.	____	____	**Do you have any concerns you would like to discuss With your health care provider?**

	Yes	No	Family History:
34.	____	____	Does anyone in your family have Marfan syndrome?
35.	____	____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.	____	____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.	____	____	Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.	____	____	Does anyone in your family have asthma?
39.	____	____	Do you or someone in your family have sickle cell trait or disease?

*Use this space to explain any **"YES"** answers from above (questions #1-39) or **to provide any additional information:***

_____

_____

40. Are you allergic to any prescription or over-the-counter medications? If yes, list: _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____

42. Year of last vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? **Most** _____ **Least** _____

44. Are you happy with your current weight? **Yes** ____ **No** ____ **If no**, how many pounds would you like to lose or gain? Lose ____ Gain ____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____
2. How many periods have you had in the last 12 months? _____

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 _____ / _____ Repeat, if abnormal _____ / _____ Vision R 20/ _____ Vision 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. Pulse (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals – Hernia			
13. Musculoskeletal – ROM, strength, etc. *(See questions 24-31)*			
14. Neurological			

Comments regarding abnormal findings: _____

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 Documents Follow up of** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** _____

Licensed Professional's Name (Printed) **Date of PPE**

Licensed 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.

Parent or Guardian (*Printed*) 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. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form.