

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		Yes	No	
1.	_____	_____	Allergies to medication, pollen, stinging insects, food, etc.?	20.	_____	Head injury, concussion, unconsciousness?--
2.	_____	_____	Any illness lasting more than one (1) week?	21.	_____	Headache, memory loss, or confusion with contact?
3.	_____	_____	Asthma or difficulty breathing during exercise?	22.	_____	Numbness, tingling or weakness in arms or legs with contact?
4.	_____	_____	Chronic or recurrent illness or injury?	*****		
5.	_____	_____	Diabetes?	23.	_____	Severe muscle cramps or illness when exercising in the heat?
6.	_____	_____	Epilepsy or other seizures?	*****		
7.	_____	_____	Eyeglasses or contacts?	24.	_____	Fracture, stress fracture or dislocated joint(s)?
8.	_____	_____	Herpes or MRSA?	25.	_____	Injuries requiring medical treatment?
9.	_____	_____	Hospitalizations (Overnight or longer)?	26.	_____	Knee injury or surgery?
10.	_____	_____	Marfan Syndrome?	27.	_____	Neck injury?
11.	_____	_____	Missing organ (eye, kidney, testicle)?	28.	_____	Orthotics, braces, protective equipment?
12.	_____	_____	Mononucleosis or Rheumatic fever?	29.	_____	Other serious joint injury?
13.	_____	_____	Seizures or frequent headaches?	30.	_____	Painful bulge or hernia in the groin area?
14.	_____	_____	Surgery?	31.	_____	X-rays, MRI, CT scan, physical therapy?

15.	_____	_____	Chest pressure, pain, or tightness with exercise?	32.	_____	Has a doctor ever denied or restricted your participation in sports for any reason?
16.	_____	_____	Excessive shortness of breath with exercise?	33.	_____	Do you have any concerns you would like to discuss with your health care provider?
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?			
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 your family have asthma?			

Use this space to explain any "YES" answers from above (questions #1-35) or to provide any additional information:

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

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

41. Year of last known vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____

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

43. 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 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 _____

Parent's or Guardian's Permission and Release

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 also give my permission for the team physician, athletic trainer, or other qualified personnel to give first aid treatment to this student at an athletic event in case of injury.

Typed or Printed Name of Parent or Guardian _____

Signature of Parent or Guardian _____

Address _____

Phone _____

Date _____