PHYSICAL EXAMINATION (2 PAGES)

It is required all students complete a history and physical examination prior to his/her first practice in a middle school (6-8) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1st for the following years activities. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 6th 7th, and 8th grade years and must be submitted to the school administration prior to the first practice.

Name:______________________ Sex: M / F Date of birth:__________ Age: ________

Address:______________________ Phone:______________________

School:______________________ Sports: ______________ Participation Grade: ________

MEDICAL HISTORY

Fill in details of "YES" answers in space below:	Yes	No		Yes	No
1. Have you ever been hospitalized?	☐	☐	6. Have you ever had a head injury?	☐	☐
Have you ever had surgery?	☐	☐	Have you ever been knocked out or unconscious?	☐	☐
2. Are you presently taking any medication or pills?	☐	☐	Have you ever been diagnosed with a concussion?	☐	☐
3. Do you have any allergies (medicine, bees, other insects)?	☐	☐	Have you ever had a seizure?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐	Have you ever had a stinger, burned or pinched nerve?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐	7. Have you ever had heat or muscle cramps?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐	Have you ever been dizzy or passed out in the heat?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐	8. Do you have trouble breathing or do you cough during or after exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐			
Have you been told you have a heart murmur?	☐	☐	9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc.)?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐			
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐	10. Have you ever had problems with your eyes or vision?	☐	☐
			Do you wear glasses, contacts or protective eyewear?	☐	☐
5. Do you have any skin problems (itching, rash, acne)?	☐	☐	11. Have you had any other medical problems (infectious mononucleosis, diabetes, ect.)?	☐	☐

12. Have you had a medical problem or injury since your last evaluation? ☐ Yes ☐ No

13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?

☐ head ☐ back ☐ shoulder ☐ forearm ☐ hand ☐ hip ☐ knee ☐ ankle

☐ neck ☐ chest ☐ elbow ☐ wrist ☐ finger ☐ thigh ☐ shin ☐ foot

14. Were you born withou a kidney, testicle, or any other organ? ☐ Yes ☐ No

15. When was your first menstrual period? ______________________

When was your last menstrual period? ______________________

What was the longest time between your periods last year? ______________

Explain "YES" answers: ____

____

CONSENT FORM

(Parent or guardian and student permission and approval)

I herby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

PARENT OR GUARDIAN SIGNATURE______________________________DATE: ____________

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulation of the State Association.

SIGNATURE OF STUDENT ______________________________ DATE: ____________

Physical Examination Form

Name:________________________________**Date of Birth:** ____________

Height__________**Weight**____________**BP**______/______**Pulse** ________ **Vision R 20 /**_____**L 20 /**______ **Corrected: Y N**		
	Normal	**Abnormal findings**
Medical		
Pulses		
Heart		
Lungs		
Skin		
Ears, nose, throat		
Abdomen		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE / RECOMMENDATIONS

Clearance:

A. Cleared for all sports and other school-sponsored activates.

B. Cleared after completing evaluation/rehabilitation for:

____

C. <u>NOT</u> cleared to participate in the following IHSAA sponsored sports /activities:

baseball basketball cheer/dance cross country football golf

soccer softball swimming tennis track volleyball wrestling

<u>NOT</u> cleared for other school-sponsored activities *(example: lacrosse)*:

____

D. Student is <u>NOT</u> permitted to participate in high school athletics.

Reason: ____

Recommendation:

Name of physician:

Address:____Phone: _______________________

Signature of physician/medical provider:____ Date: ____________

(This *Physical Examination Form* MUST be signed by a licensed physician, physician assistant or nurse practitioner)