USE THIS FORM FOR INITIAL PHYSICAL EXAM

Instructions for use of pre-participation (athletic)
Health Examination and Consent Form

Instructions for completing FORM A

COMPLETING THIS FORM:
1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian with the student are to complete the Health History on page 3 of Form A and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:
1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed and the Pre-participation Physical Evaluation (FORM A) must be completed before any student may participate in athletic activities sponsored by this Association. Clearance Form (Form B) must be completed by the parent each subsequent year. A re-evaluation physical examination will be required if any changes appear for questions 1-16 on the Health History form (Form B). Forms A and B along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician’s Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.
Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on Health Examination Form A or B.

Name of Student _____________________________ School _____________________________

Is the student covered by health/accident insurance? □ Yes  □ No

Name of health insurance provider _____________________________
If no insurance provider, explain _____________________________

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student’s school. I agree that if my student’s health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above.  http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf

Parent or Guardian Name _____________________________ Parent or Guardian Signature _____________________________

Date _____________________________

Student Statement

By signing below I acknowledge:

- 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 regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student _____________________________ Date _____________________________

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.
**Pre-Participation Physical Evaluation**

**Health History**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Phone</th>
<th>Personal Physician</th>
<th>In case of emergency, contact:</th>
<th>Name</th>
<th>Relationship</th>
<th>Phone(H)</th>
<th>Phone(W)</th>
</tr>
</thead>
</table>

**Explain "Yes" answers below**

Circle questions you don't know the answers to

Yes | No | Yes | No
---|---|---|---
1. Have you had a medical illness or injury since your last check-up or sports physical?
2. Have you ever been hospitalized overnight?
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?
5. Have you ever had a rash or hives develop during or after exercise?
6. Have you ever consumed alcohol or drugs?
7. Have you ever had a head injury or concussion?
8. Have you ever become ill from exercising in the heat?
9. Do you cough, wheeze, or have trouble breathing during or after activity?
10. Do you have any special or corrective equipment or devices that aren't usually used for your sport or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid, etc.)
11. Have you had any problems with your eyes or vision?
12. Do you wear glasses, contacts, or protective eyewear?
13. Have you ever had a sprain, strain or swelling after injury?
14. Have you broken or fractured any bones or dislocated any joints?
15. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
16. Do you want to weigh more or less than you do now?
17. Do you lose weight regularly to meet weight requirements for your sport?
18. Do you feel stressed out?
19. Record the dates of your most recent immunizations:
   - Tetanus
   - Measles
   - Hepatitis B
   - Chickenpox

**FEMALES ONLY**

16. When was your first menstrual period?
17. When was your most recent menstrual period?
18. How much time do you usually have from the start of one period to the start of another?
19. How many periods have you had in the last year?
20. What was the longest time between periods in the last year?

**EXPLAIN ANY YES ANSWERS HERE**

---

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

<table>
<thead>
<tr>
<th>Signature of Student</th>
<th>Signature of Parent</th>
<th>Date</th>
</tr>
</thead>
</table>

*Form A, Updated September, 2011*  
*Page 3 of 4*
Pre-Participation Physical Evaluation

Physical Examination

Name ___________________________________________ Date of Birth __________________________

Height ___________ Weight ___________ % Body Fat (Optional) ___________ Pulse ___________

BP ___________ / ___________ ( _______ / _______ )

Vision R 20/ ___________ L 20/ ___________ Corrected Y N Pupils: Equal _______ Unequal _______

MEDICAL

Normal Abnormal Findings Initials*

Appearance

Eyes/Ears/Nose/Throat

Lymph Nodes

Heart

Pulses

Lungs

Abdomen

Genitalia (males only)

Skin

MUSCULOSKELETAL

Neck

Back

Shoulder/Arm

Elbow/Forearm

Wrist/Hand

Hip/Thigh

Knee

Leg/Ankle

Foot

*Stevan-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ___________________________________________

☐ Not cleared for: ___________________________ Reason: ___________________________

Recommendations: _____________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Name of Physician (print/type) ___________________________ Date ___________

Address ___________________________ Phone ___________

Signature of physician ___________________________ MD, DO, PAC, RNP, DC