## Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name______________________________ Sport/Position______________
Last First Middle

Social Security Number____________________ School Year______________

Address__________________________________________

City/State____________________ Phone No.______________

Birthdate__________ Age_____ Class______ Student ID No.______________

Parent's Name__________________________________________

Address__________________________________________

Phone No.______________________

Person to contact in case of emergency______________________________

Phone No.______________________

Family Doctor____________________ City/State______________

Phone No.______________________

## Past Medical History

| | | Yes | No | If yes, please explain (what, where, when) |
|---|---|---|---|---|
| 1. | Presently taking medication (including birth control pills)? | ____ | ____ | ________ |
| 2. | Have you been diagnosed with asthma? | ____ | ____ | ________ |
| 3. | Have you been prescribed by a physician to use any asthma medication? | ____ | ____ | ________ |
| 4. | Do you have a current consent form to self-administer the asthma medication on file with your school? | ____ | ____ | ________ |
| 5. | Allergic to medicine, foods, bee stings? | ____ | ____ | ________ |
| 6. | Wears any appliances – glasses, contact lenses? | ____ | ____ | ________ |
| 7. | History of braces, chipped teeth, bridges? | ____ | ____ | ________ |
| 8. | Has ongoing medical problem? | ____ | ____ | ________ |
| 9. | Had serious or significant illness in past? | ____ | ____ | ________ |
| 10. | Any past surgical operations, accidents, non-sports or related injuries? | ____ | ____ | ________ |
| 11. | Any past injuries directly related to sports? | ____ | ____ | ________ |
| 12. | Any hospitalization not explained above? | ____ | ____ | ________ |
| 13. | Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)? | ____ | ____ | ________ |
| 14. | Any serious family illness (such as diabetes, bleeding disorders, etc.)? | ____ | ____ | ________ |
| 15. | Family history of cancer? | ____ | ____ | ________ |
| 16. | Heart | | | |
| | Have you ever passed out during or after exercise? | ____ | ____ | ________ |
| | Have you ever had chest pain during or after exercise? | ____ | ____ | ________ |
| | Do you get tired more quickly than your friends do during exercise? | ____ | ____ | ________ |
| | Have you ever had racing of your heart or skipped heartbeats? | ____ | ____ | ________ |
| | Have you had high blood pressure or high cholesterol? | ____ | ____ | ________ |
| | Have you ever been told you have a heart murmur? | ____ | ____ | ________ |
| | Has any family member or relative died of heart problems or of sudden death before age 50? | ____ | ____ | ________ |
| | Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? | ____ | ____ | ________ |
| | Has a physician ever denied or restricted your participation in sports for any heart problems? | ____ | ____ | ________ |
| | Has anyone in your family had a heart attack before the age of 50? | ____ | ____ | ________ |
| 17. | Head and Nerve | ____ | ____ | ________ |
| | Have you ever had a head injury or concussion? | ____ | ____ | ________ |
| | Have you ever been knocked out, become unconscious, or lost your memory? | ____ | ____ | ________ |
| | Have you ever had a seizure? | ____ | ____ | ________ |
| | Do you have frequent or severe headaches? | ____ | ____ | ________ |
| | Have you ever had numbness or tingling in your arms, hands, legs or feet? | ____ | ____ | ________ |
| | Have you ever had a stinger, burner, or pinched nerve? | ____ | ____ | ________ |
| 18. | Last tetanus shot? | Date ____ | | |
| 19. | Last eye exam? | Date ____ | | |
| 20. | Last Menstrual period (if women) | Date ____ | | |

## Personal Habits

| | | Yes | No |
|---|---|---|---|
| 1. | Smoking/smokeless tobacco | ____ | ____ |
| 2. | Alcohol/non-medical drugs: marijuana, cocaine, etc. | ____ | ____ |
| 3. | Steroids | ____ | ____ |
| 4. | Eating Disorders – weight loss or gain? | ____ | ____ |

Review of systems (Please check if you have any problems with any of the following areas of your body)

| | | | | | |
|---|---|---|---|---|---|
| ____ | Skin | ____ | Lungs | ____ | Shoulders, Arms, Hands |
| ____ | Head | ____ | Heart | ____ | Hips, Legs, Feet |
| ____ | Eyes | ____ | Abdomen | ____ | Muscle–Strength, Feeling |
| ____ | Nose | ____ | Back | ____ | Mental, Emotional |
| ____ | Mouth/Throat | ____ | Urination, Bowel Control | ____ | Fatigue |
| ____ | Nutrition, Weight Control | ____ | Genital (including menstrual for women) | ____ | Other: What? |
| ____ | Neck | ____ | | | ________ |

I certify that the above information is correct to the best of my knowledge.

Student Signature______________________________

Parent/Guardian Signature______________________________

**Both Student and Parent/Guardian Signatures Are Mandatory**

## Physical Examination

Height___________ Weight___________ Blood Pressure___________

Pulse: resting_____ 15 hops_________ after 2 minutes resting_______

Visual Acuity: Eyes (R) 20/___ w/o glasses_____ (L) 20/_______ w/glasses_______

| Other Testing | Normal | Abnormal Findings |
|---|---|---|
| 1. General | | |
| 2. Skin | | |
| 3. HEENT | | |
| 4. Teeth (Dental Exam) | | |
| 5. Neck | | |
| 6. Lungs | | |
| 7. Heart (Sit and Stand) | | |
| 8. Abdomen | | |
| 9. Genitalia | | |
| 10. Musculoskeletal | | |
| Neck | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand | | |
| Back | | |
| Hip/Thigh | | |
| Knee | | |
| Shin/Calf | | |
| Ankle/Leg | | |
| Foot | | |
| 11. Peripheral Pulses | | |
| 12. Neurologic | | |
| 13. Mental Status | | |
| 14. Marfan Screen | | |

Other Tests (optional)

_________ Auditory _________ U/A _________ EKG
_________ % Body Fat _________ Drug Screen _________ Chest X-Ray
_________ Hgb/Hct _________ SMAC _________ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes_____________ No_____________ Limited__________

Additional Comments:

Examination Date_________ Physician's Signature______________________________

Physician's Assistant Signature*______________________________

Advanced Nurse Practitioner's Signature*______________________________

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

**Student's Name__________________ School Name__________________**

## Consent Form to Self-Administer Asthma Medication

**(not needed if current form is already on file with school)**

**Parent Consent**

I, ____________________, do hereby give my son/daughter, ________________________, Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

______________________ Parent's Signature ____________ Date

**Physician Consent**

As a patient under my care, ______________________, is prescribed to self-administer the following asthma medication.

Medication______________________________________

Purpose______________________________________

Dosage______________________________________

Time/Special Circumstances______________________________________

______________________________________

______________________ Physician's Signature ____________ Date

## IHSA Substance Testing Policy Consent to Random Testing

(This section for high school students only)

**2010-11 school term**

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

______________________ Signature of student-athlete ____________ Date

______________________ Signature of parent-guardian ____________ Date