

## 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.)**

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| <p><b>Yes No Does this student have / ever had?</b></p> <p>1. _____ Allergies to medication, pollen, stinging insects, food, etc.?</p> <p>2. _____ Any illness lasting more than one (1) week?</p> <p>3. _____ Asthma or difficulty breathing during exercise?</p> <p>4. _____ Chronic or recurrent illness or injury?</p> <p>5. _____ Diabetes?</p> <p>6. _____ Epilepsy or other seizures?</p> <p>7. _____ Eyeglasses or contacts?</p> <p>8. _____ Herpes or MRSA?</p> <p>9. _____ Hospitalizations (Overnight or longer)?</p> <p>10. _____ Marfan Syndrome?</p> <p>11. _____ Missing organ (eye, kidney, testicle)?</p> <p>12. _____ Mononucleosis or Rheumatic fever?</p> <p>13. _____ Seizures or frequent headaches?</p> <p>14. _____ Surgery?</p> <p>*****</p> <p>15. _____ Chest pressure, pain, or tightness with exercise?</p> <p>16. _____ Excessive shortness of breath with exercise?</p> <p>17. _____ Headaches, dizziness or fainting during, or after, exercise?</p> <p>18. _____ Heart problems (Racing, skipped beats, murmur, infection, etc.?)</p> | <p>19. _____ High blood pressure or high cholesterol?</p> <p><b>Yes No Does this student have / ever had?</b></p> <p>20. _____ Head injury, concussion, unconsciousness?</p> <p>21. _____ Headache, memory loss, or confusion with contact?</p> <p>22. _____ Numbness, tingling or weakness in arms or legs with contact?</p> <p>*****</p> <p>23. _____ Severe muscle cramps or illness when exercising in the heat?</p> <p>*****</p> <p>24. _____ Fracture, stress fracture or dislocated joint(s)?</p> <p>25. _____ Injuries requiring medical treatment?</p> <p>26. _____ Knee injury or surgery?</p> <p>27. _____ Neck injury?</p> <p>28. _____ Orthotics, braces, protective equipment?</p> <p>29. _____ Other serious joint injury?</p> <p>30. _____ Painful bulge or hernia in the groin area?</p> <p>31. _____ X-rays, MRI, CT scan, physical therapy?</p> <p>*****</p> <p><b>32. _____ Has a doctor ever denied or restricted your participation in sports for any reason?</b></p> <p><b>33. _____ Do you have any concerns you would</b></p> |
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- 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 your family have asthma?

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

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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: Tetanus (lockjaw) vaccination: \_\_\_\_\_ Meningitis vaccination: \_\_\_\_\_
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 completed by a licensed medical 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/ \_\_\_\_\_ L 20/ \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance (esp. Marfan's)			
Eyes/Ears/Nose/Throat			
Pupil Size (Equal/Unequal)			
Mouth & Teeth			
Neck			

(Cont.)	NORMAL	ABNORMAL FINDINGS	INITIALS
Lymph Nodes			
Heart (Standing & Lying)			
Pulses (esp. femoral)			
Chest & Lungs			
Abdomen			
Skin			
Genitals – Hernia			
Musculoskeletal – ROM, strength, etc. (See Questions 23-27)			
Neurological			

Comments regarding abnormal findings:

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**LICENSED MEDICAL PROFESSIONAL'S 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 DOCUMENTED FOLLOW UP

OF \_\_\_\_\_

NOT CLEARED FOR ATHLETIC PARTICIPATION DUE

TO \_\_\_\_\_

\_\_\_\_\_  
Licensed Medical Professional's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Medical Professional's Signature

\_\_\_\_\_  
Phone

*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.*

**Centro Escolar de la Comunidad de Council Bluffs  
Asunción de Riesgo y Formulario de Consentimiento para participar**

Por su naturaleza, la participación en el atletismo inter-escolar incluido el riesgo de lesiones, que pueden variar en gravedad de menor a discapacidad hasta incluso la muerte. Aunque las lesiones serias no son comunes en los programas escolares de atletismo supervisados, es imposible eliminar el riesgo. Los participantes pueden y tienen la responsabilidad de ayudar a reducir las probabilidades de lesiones. Los participantes deben obedecer todas las reglas de seguridad e instrucciones del entrenador, reportar todos los problemas físicos a sus entrenadores y/o entrenador, seguir un programa de condicionamiento adecuado, e inspeccionar sus propios equipos de seguridad y protección diaria.

Este formulario no exime al distrito escolar de cualquier negligencia, sin embargo, al firmar este formulario, entendemos que siempre existe el riesgo potencial de lesión para el participante. **Los padres o alumnos que NO desean aceptar los riesgos descritos anteriormente no deben firmar este formulario de consentimiento.**

Doy mi consentimiento para que X \_\_\_\_\_ (escribir nombre del alumno/nombre del participante):

1. Para representar a su escuela en las actividades atléticas aprobadas excepto las no aprobadas por el médico examinador;
2. Para acompañar a cualquier equipo de la escuela del cual él/ella es un miembro en sus viajes locales o fuera de la ciudad;
3. para recibir, a través de un médico del equipo, entrenador atlético, u otro personal cualificado de la elección de la escuela, atención médica de emergencia/tratamiento de primeros auxilios que puede llegar a ser razonablemente necesario en el curso de tales actividades atléticas o tal viaje.
4. tener a un médico o cirujano con licencia que lleve a cabo una preparación previa de examen físico y presentarlo a la escuela.

Firma del Padre/tutor legal: \_\_\_\_\_ Fecha \_\_\_\_\_

Como un estudiante participante, entiendo que mi participación es voluntaria y un privilegio, no un derecho y por lo tanto también estoy de acuerdo con todos los requisitos de Elegibilidad Académica, el requisito de Buena Conducta, y las normas Deportivas. **El incumplimiento de estos requisitos y normas pone en peligro mi derecho a participar.**

Firma del Estudiante-participante: \_\_\_\_\_ Fecha \_\_\_\_\_

**Autorización de Seguro**

Es la ley que todo estudiante que participe en la competencia inter-escolar debe estar cubierto por una póliza de seguro de accidente/salud.

\_\_\_\_\_ Nuestro hijo/a está CUBIERTO por un plan de accidente/salud con la compañía de \_\_\_\_\_.

\_\_\_\_\_ Nuestro hijo/a NO ESTÁ CUBIERTO por una póliza de seguro de accidente /salud, y vamos a comprar el plan de seguro de accidente estudiantil puestos a disposición por el distrito escolar. Entendemos que esta póliza ofrece una serie de opciones de planes. Tenemos la intención de elegir una o más de las opciones. El plan y el pago deben ser recibidos antes de participar.

\_\_\_\_\_  
Firma del Padre/Tutor legal

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Fecha