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 Does this student have / ever had?
1. _____ _____ Allergies to medication, pollen, stinging insects, food, etc.?
2. _____ _____ Any illness lasting more than one (1) week?
3. _____ _____ Asthma or difficulty breathing during exercise?
4. _____ _____ Chronic or recurrent illness or injury?
5. _____ _____ Diabetes?
6. _____ _____ Epilepsy or other seizures?
7. _____ _____ Eyeglasses or contacts?
8. _____ _____ Herpes or MRSA?
9. _____ _____ Hospitalizations (Overnight or longer)?
10. _____ _____ Marfan Syndrome?
11. _____ _____ Missing organ (eye, kidney, testicle)?
12. _____ _____ Mononucleosis or Rheumatic fever?
13. _____ _____ Seizures or frequent headaches?
14. _____ _____ Surgery?

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15. _____ _____ Chest pressure, pain, or tightness with exercise?
16. _____ _____ Excessive shortness of breath with exercise?
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?

Yes No Does this student have / ever had?

20. _____ _____ Head injury, concussion, unconsciousness?
21. _____ _____ Headache, memory loss, or confusion with contact?
22. _____ _____ Numbness, tingling or weakness in arms or legs with contact?

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23. _____ _____ Severe muscle cramps or illness when exercising in the heat?

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24. _____ _____ Fracture, stress fracture or dislocated joint(s)?
25. _____ _____ Injuries requiring medical treatment?
26. _____ _____ Knee injury or surgery?
27. _____ _____ Neck injury?
28. _____ _____ Orthotics, braces, protective equipment?
29. _____ _____ Other serious joint injury?
30. _____ _____ Painful bulge or hernia in the groin area?
31. _____ _____ X-rays, MRI, CT scan, physical therapy?

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32. _____ _____ Has a doctor ever denied or restricted your participation in sports for any reason?
33. _____ _____ Do you have any concerns you would

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**:*

____
____
____

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). ***Thisevaluation 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.

Parent & Student Portion:

Council Bluffs Community School District

Acknowledgement of Risk and Consent to Participate Form

By its nature, participation in interscholastic athletics included risk of injury, which may range in severity from minor to disabling to even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants can and have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and coaches' instructions, report all physical problems to their coaches and/or trainer, follow a proper conditioning program, and inspect their own protective safety equipment daily.

This form does not release the school district from any negligence, however, by signing this form, we understand that there is always the potential risk of injury to the participant**. Parents or Students who DO NOT wish to accept the risks described above should not sign this consent form.**

Parent's or Guardian's Permission and Release

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also **give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

I hereby give my consent for ______________________________ (print student/participant name):

1. To represent his/her school in approved athletic activities except those not approved by the examining medical doctor:
2. to accompany any school team of which he/she is a member on it local or out-of-town trips;
3. to receive, through a team physician, athletic trainer, or other qualified personnel of the school's choice, emergency medical care/first aid treatment that may become reasonably necessary in the course of such athletic activities or such travel.
4. to have a licensed physician or surgeon conduct a pre-participation Physical Examination and submit it to the school

Parent/Legal Guardian Signature: ______________________________Date___________

As a student participant I understand my participation is voluntary and a privilege, not a right and therefore also agree to all Academic Eligibility requirements, Good Conduct requirement, and Sportsmanship rules. **<u>Failure to abide by these requirements and rules jeopardize my eligibility to participate.</u>**

Student-Participant Signature: ______________________________Date___________

Insurance Release

It is Iowa law that a student participating in interscholastic competition must be covered by an accident/health insurance policy.

______Our son/daughter IS COVERED by an accident/health plan with ________ insurance company.

______Our son/daughter IS NOT COVERED by an accident/health insurance policy, and we will purchase the student accident insurance plan made available by the school district. We understand this policy provides a number of plan options. We intend to choose one or more of the options. Plan and payment must be received prior to participation.

______________________________ ________________

Parent/Legal Guardian Signature Date