Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name____ School Year__________
Last First Middle

Address______________________________ City/State______________________

Phone No.__________ Birthdate__________ Age______ Class______ Student ID No.__________

Parent's Name______________________________ Phone No.__________________

Address______________________________ City/State______________________

HISTORY/SYSTEMS REVIEW

GENERAL QUESTIONS		YES	No
1.	Presently taking medication (including birth control)?		
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.	Last tetanus shot? Date:		
9.	Last eye exam? Date:		
10.	Last Menstrual Period (if women) Date:		
11.	Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
MEDICAL QUESTIONS		**YES**	**No**
1.	Has ongoing medical problem?		
2.	Had serious or significant illness in past?		
3.	Any past surgical operations, accidents, non-sports or related injuries?		
4.	Any past injuries directly related to sports?		
5.	Any hospitalization not explained above?		
6.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?		
7.	Any serious family illness (such as diabetes, bleeding disorders, etc.)?		
8.	Family history of cancer?		
9.	Have you ever become ill while exercising in the heat?		
10.	Do you get frequent muscle cramps when exercising?		
11.	Do you or someone in your family have sickle cell trait or disease?		
12.	Do you have any concerns that you would like to discuss with a doctor?		
HEAD and NERVE		**YES**	**No**
1.	Have you ever had a head injury or concussion?		
2.	Have you ever been knocked out, become unconscious, or lost your memory?		
3.	Have you ever had a seizure?		
4.	Do you have frequent or severe headaches?		
5.	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
6.	Have you ever had a stinger, burner, or pinched nerve?		

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?		
HEART		**YES**	**No**
1.	Have you ever passed out during or after exercise?		
2.	Have you ever had chest pain during or after exercise?		
3.	Do you get tired more quickly than your friends do during exercise?		
4.	Have you ever had racing of your heart or skipped heartbeats?		
5.	Have you had high blood pressure or high cholesterol?		
6.	Have you ever been told you have a heart murmur?		
7.	Has any family member or relative died of heart problems or of sudden death before age 50?		
8.	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?		
9.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
10.	Has anyone in your family had a heart attack before the age of 50?		

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

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

______________________________ __________
Signature of student-athlete Date

______________________________ __________
Signature of parent-guardian Date

Pre-participation Examination

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	
% Body Fat	
Hgb/Hct	
U/V	
Drug Screen	
SMAC	
EKG	
Chest X-Ray	
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 ____________ Examination Date ____________

Additional Comments:

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.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
2011-2012 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