



Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name _____
Last First Middle Sport/Position _____

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?	_____	_____	_____

	Yes	No	If yes, please explain (what, where, when)
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

