



Preparticipation 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?	_____	_____	_____

	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,	_____ Fatigue
_____ Nutrition,	_____ Bowel Control	_____ Other: What?
_____ Weight Control	_____ Genital (including menstrual for women)	_____
_____ 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/V _____ 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 Steroid Testing Policy Consent to Random Testing

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing dietary supplements of teams and individuals qualifying for state finals competition.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

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

Signature of student-athlete

Date

Signature of parent-guardian

Date

