

- Yes No**
9. Have you ever been dizzy during or after exercise?
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
11. Have you ever become ill from exercising in the heat?
12. Have you had any problems with your eyes or vision?
13. Have you ever gotten unexpectedly short of breath with exercise?
- Do you have asthma?
- Do you have seasonal allergies that require medical treatment?
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
15. Have you ever had a sprain, strain, or swelling after injury?
- Have you broken or fractured any bones or dislocated any joints?
- Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?
- If yes, check appropriate box and explain below.

- | | | |
|---------------------------------|-------------------------------|---------------------------------|
| <input type="radio"/> Head | <input type="radio"/> Elbow | <input type="radio"/> Hip |
| <input type="radio"/> Neck | <input type="radio"/> Forearm | <input type="radio"/> Thigh |
| <input type="radio"/> Back | <input type="radio"/> Wrist | <input type="radio"/> Knee |
| <input type="radio"/> Chest | <input type="radio"/> Hand | <input type="radio"/> Shin/Calf |
| <input type="radio"/> Shoulder | <input type="radio"/> Finger | <input type="radio"/> Ankle |
| <input type="radio"/> Upper Arm | <input type="radio"/> Foot | |

16. Do you want to weigh more or less than you do now?
- Do you lose weight regularly to meet weight requirements for your sport?
17. Do you feel stressed out?
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?

Females Only

19. When was your first menstrual period?
 When was your most recent menstrual period?
 How much time do you usually have from the start of one period to the start of another?
 How many periods have you had in the last year?
 What was the longest time between periods in the last year?

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

****EXPLAIN 'YES' ANSWERS ON A SEPARATE SHEET OF PAPER (attach another sheet):**

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.
 If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.
 If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by PATTEN

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

**THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.
 For School Use Only:**

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____/_____/____ (____/____, ____/____)
 brachial blood pressure while sitting
 Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal Pupil Distance _____mm
 As a minimum requirement, this **Physical Examination Form** must be completed prior to athletic participation.

NORMAL ABNORMAL FINDINGS INITIALS*

MEDICAL	
Appearance	
Eyes/Ears/Nose/Throat	
Lymph Nodes	
Heart-Auscultation of the heart in the supine position.	
Heart-Auscultation of the heart in the standing position.	
Heart-Lower extremity pulses	
Pulses	
Lungs	
Abdomen	
Genitalia (males only)	
Skin	
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)	
MUSCULOSKELETAL	
Neck	
Back	
Shoulder/Arm	
Elbow/Forearm	
Wrist/Hand	
Hip/Thigh	
Knee	
Leg/Ankle	
Foot *station-based examination only	

CLEARANCE

Cleared
 Cleared after completing evaluation/rehabilitation for: _____
 Not cleared for: _____ Reason: _____
 Recommendations: _____

Name (print/type) _____ Date of Examination: _____
 Address: _____
 Phone Number: _____
 Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.