

# 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 (Street, City, Zip) \_\_\_\_\_ School District \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

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.)**

- | <b>Yes</b> | <b>No</b> | <b>Does this student have / ever had?</b>                        | <b>Yes</b> | <b>No</b> | <b>Does this student have / ever had?</b>  |
|------------|-----------|--|------------|-----------|--|
| 1. _____   | _____     | Allergies to medication, pollen, stinging insects, food, etc.?   | 20. _____  | _____     | Head injury, concussion, unconsciousness?  |
| 2. _____   | _____     | Any illness lasting more than one (1) week?                      | 21. _____  | _____     | Headache, memory loss, or confusion with contact?  |
| 3. _____   | _____     | Asthma or difficulty breathing during exercise?                  | 22. _____  | _____     | Numbness, tingling or weakness in arms or legs with contact?                               |
| 4. _____   | _____     | Chronic or recurrent illness or injury?                          | *****      |           |  |
| 5. _____   | _____     | Diabetes?  | 23. _____  | _____     | Severe muscle cramps or illness when exercising in the heat?                               |
| 6. _____   | _____     | Epilepsy or other seizures?                                      | *****      |           |  |
| 7. _____   | _____     | Eyeglasses or contacts?  | 24. _____  | _____     | Fracture, stress fracture or dislocated joint(s)?  |
| 8. _____   | _____     | Herpes or MRSA?  | 25. _____  | _____     | Injuries requiring medical treatment?  |
| 9. _____   | _____     | Hospitalizations (Overnight or longer)?                          | 26. _____  | _____     | Knee injury or surgery?  |
| 10. _____  | _____     | Marfan Syndrome?   | 27. _____  | _____     | Neck injury?   |
| 11. _____  | _____     | Missing organ (eye, kidney, testicle)?                           | 28. _____  | _____     | Orthotics, braces, protective equipment?   |
| 12. _____  | _____     | Mononucleosis or Rheumatic fever?                                | 29. _____  | _____     | Other serious joint injury?  |
| 13. _____  | _____     | Seizures or frequent headaches?                                  | 30. _____  | _____     | Painful bulge or hernia in the groin area?   |
| 14. _____  | _____     | Surgery?   | 31. _____  | _____     | X-rays, MRI, CT scan, physical therapy?  |
| *****      |           |  |            |           |  |
| 15. _____  | _____     | Chest pressure, pain, or tightness with exercise?                | 32. _____  | _____     | <b>Has a doctor ever denied or restricted your participation in sports for any reason?</b> |
| 16. _____  | _____     | Excessive shortness of breath with exercise?                     | 33. _____  | _____     | <b>Do you have any concerns you would like to discuss with your health care provider?</b>  |
| 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 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 in your family have asthma?
39. \_\_\_\_\_ Do you or someone in your family have sickle cell trait or disease?

Use this space to explain any "YES" answers from above (questions #1-38) or to provide any additional information:

\_\_\_\_\_

\_\_\_\_\_

40. Are you allergic to any prescription or over-the-counter medications? If yes, list: \_\_\_\_\_
41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:  
A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_
42. Year of last known vaccination: Tetanus: \_\_\_\_\_ Meningitis: \_\_\_\_\_ Influenza: \_\_\_\_\_
43. What is the most and least you have weighed in the past year? Most \_\_\_\_\_ Least \_\_\_\_\_
44. 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). *This evaluation 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/ \_\_\_\_\_

	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS</b>
1. Appearance (esp. Marfan's ) _____			
2. Eyes/Ears/Nose/Throat _____			
3. Pupil Size (Equal/Unequal) _____			
4. Mouth & Teeth _____			
5. Neck _____			
6. Lymph Nodes _____			
7. Heart (Standing & Lying) _____			
8. Pulses (esp. femoral) _____			
9. Chest & Lungs _____			
10. Abdomen _____			
11. Skin _____			
12. Genitals - Hernia _____			
13. Musculoskeletal - ROM, strength, etc. (See questions 24-31) _____			
14. Neurological _____			

**Comments regarding abnormal findings:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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 of PPE**

\_\_\_\_\_  
**Licensed Medical Professional's Signature** \_\_\_\_\_ **Phone**

**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.

\_\_\_\_\_  
 Name of Parent or Guardian (Printed) \_\_\_\_\_ Signature of Parent of Guardian

\_\_\_\_\_  
 Address (Street/PO Box, City, State, Zip) \_\_\_\_\_ Phone Number