Pre-participation 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?			
	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

IHSA ILLINOIS HIGH SCHOOL ASSOCIATION

IESA