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, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, 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.)

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

	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: Tdap (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).

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____/_____ *(Repeat, if abnormal _____/_____)* Vision R 20/_____ L 20/_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
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

(Please be precise when indicating at which level the student is cleared to participate.)

1. _____ **FULL & UNLIMITED PARTICIPATION**
2. _____ **LIMITED PARTICIPATION** - *May **NOT** participate in the following (checked):*

   _____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

   _____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling
3. _____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____
4. _____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** _____

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/illness and to share necessary information about the injury/illness with appropriate school personnel.

Name of Parent or Guardian, or student if 18 years of age *(Printed)* Signature of Parent of Guardian, or student if 18 years of age

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

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. 08/15

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

(1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
(2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
(3) Key definitions:
"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
"Extracurricular interscholastic activity" means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?
A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?
1. **OBEY THE NEW LAW.**
   a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
   b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?
You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:
If you think you have a concussion:
- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

Signs Reported by Students:
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

PARENTS:
How can you help your child prevent a concussion?
Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.
- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs Observed by Parents or Guardians:
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.
For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature _____ Date _____ Student's Printed Name _____

Parent's/Guardian's Signature _____ Date _____ Student's Grade _____ Student's School _____

May 2012-CE

RELEASE AND ACTIVITY PARTICIPATION

Your son/daughter has expressed a desire to participate in Union High School activities. There is information concerning such participation that is vital for a successful experience. Please read this information carefully. If you have any questions, please contact or call your child's coach or the school athletic director. Before the athlete is allowed to practice or check out uniforms, you are required to read, sign, and return this Release and Activity Participation Document to the appropriate head coach or school office.

1. Each athlete must have on file a passed physical examination. The examination or questionnaire must be completed prior to beginning practice. Costs incurred for the physical examination will be the responsibility of the parent/guardian.

NOTICE OF RISK: Student athletes and the student's parent/guardian need to be aware that sport activities involve risk of injury. When an athlete practices, plays, or participates in any sport, the activity can be dangerous. The student risks serious and permanent injury affecting their wellbeing. Instructions given by the coach regarding playing techniques, training, and team rules must be followed.

2. Union Community School District is not liable or responsible for any medical, dental, or hospital bills, occurring as a result of injuries sustained by a student while participating in a school athletic activity or sport. ALL injury related expenses should be the responsibility of the student's parents/guardians.
3. **Must check one of the below:**

   _____ I have insurance that will pay for medical expenses if my son/daughter, _____ is injured while participating in a school sport.

   Insurance Company: _____

   Or:

   _____ I do not have insurance for my son/daughter, _____, and I understand that the Union Community School District is NOT responsible and WILL NOT PAY any doctor, hospital and/or medical expenses if my child is injured while participating in any school sport.
4. Recognizing that as a result of athletic participation, medical treatment on an emergency basis may be necessary and school personnel may be unable to contact me for my consent for emergency medical care, I do hereby consent in advance to such emergency medical care, including test, x-rays, surgery, and hospital care as may be deemed necessary under the then existing circumstance.
5. TRANSPORTATION:
   a) The Union Community School District provides transportation for participants both to and from the location of the contest during the normal school day (that is, games immediately following the school day).
   b) Participants must be transported by District transportation to and from school activities. A Parent/guardian may transport their child home when written request is given to the coach or thru face-to-face request after the school activity.
6. All participants are expected to conform to the rules of scholastic eligibility, participation and training as prescribed by the Iowa High School Activities Association, the Union School District, Union High School code of Conduct, and the coaching staffs (this information will be reviewed prior to the start of the season with each participant).
7. Union Community School District has contracted a licensed athletic trainer and I agree that they may evaluate and treat my son/daughter as needed, or as recommended, by a school coach or employee. I also agree that they may release medical information to teachers, coaches and other school personnel.

I have carefully read, understand, and will comply with all the information discussed in the RELEASE AND PARTICIPATION form.

_____ _____

Signature of Parent/Guardian Date
(first and last name)

Signature of Student Date
(first and last name)