



Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name: Last, First, Middle, Sport/Position, School Year, Social Security Number, 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

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?
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?
19. Last eye exam?
20. Last Menstrual period (if women)

Personal Habits

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, Head, Eyes, Nose, Mouth/Throat, Nutrition, Weight Control, Neck, Lungs, Heart, Abdomen, Back, Urination, Bowel Control, Genital (including menstrual for women), Fatigue, Shoulders, Arms, Hands, Hips, Legs, Feet, Muscle-Strength, Feeling, Mental, Emotional, Other: What?

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/\_\_\_\_ (L) 20/\_\_\_\_ w/o glasses \_\_\_\_\_ 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	_____	_____
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](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf)

Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent-guardian \_\_\_\_\_ Date \_\_\_\_\_

