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.)

	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). ***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/_____

	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

Concussion Symptom Checklist

Student name:	Date:	Time:
Person completing checklist (if not the student):	☐ Baseline*	☐ Post injury*

Symptoms	Severity Rating						
☐ **1.** I feel like I'm going to faint	0	1	2	3	4	5	6
☐ **2.** I'm having trouble balancing	0	1	2	3	4	5	6
☐ **3.** I feel dizzy	0	1	2	3	4	5	6
☐ **4.** It feels like the room is spinning	0	1	2	3	4	5	6
☐ **5.** Things look blurry	0	1	2	3	4	5	6
☐ **6.** I see double	0	1	2	3	4	5	6
☐ **7.** I have headaches	0	1	2	3	4	5	6
☐ **8.** I feel sick to my stomach (nauseated)	0	1	2	3	4	5	6
☐ **9.** Noise/sound bothers my eyes	0	1	2	3	4	5	6
☐ **10.** The light bothers my eyes	0	1	2	3	4	5	6
☐ **11.** I have pressure in my head I feel numbness and tingling	0	1	2	3	4	5	6
☐ **12.** I feel numbness and tingling	0	1	2	3	4	5	6
☐ **13.** I have neck pain	0	1	2	3	4	5	6
☐ **14.** I have trouble falling asleep	0	1	2	3	4	5	6
☐ **15.** I feel like sleeping too much	0	1	2	3	4	5	6
☐ **16.** I feel like I am not getting enough sleep	0	1	2	3	4	5	6
☐ **17.** I have low energy (fatigue)	0	1	2	3	4	5	6
☐ **18.** I feel tired a lot (drowsiness)	0	1	2	3	4	5	6
☐ **19.** I have trouble paying attention	0	1	2	3	4	5	6
☐ **20.** I am easily distracted	0	1	2	3	4	5	6
☐ **21.** I have trouble concentrating	0	1	2	3	4	5	6
☐ **22.** I have trouble remembering things	0	1	2	3	4	5	6
☐ **23.** I have trouble following directions	0	1	2	3	4	5	6
☐ **24.** I feel like I am moving at a slower speed	0	1	2	3	4	5	6
☐ **25.** I don't feel "right"	0	1	2	3	4	5	6
☐ **26.** I feel confused	0	1	2	3	4	5	6
☐ **27.** I have trouble learning new things	0	1	2	3	4	5	6
☐ **28.** I feel like my thinking is "foggy"	0	1	2	3	4	5	6
☐ **29.** I feel sad	0	1	2	3	4	5	6
☐ **30.** I feel nervous	0	1	2	3	4	5	6
☐ **31.** I feel irritable or grouchy	0	1	2	3	4	5	6
☐ **32.** I feel more emotional	0	1	2	3	4	5	6
☐ **33.** Other:	0	1	2	3	4	5	6

*For baseline, student should rate symptoms based on how he/she typically feels. For post-injury, student should rate symptoms, at this point in time.

Credit: HCA HealthONE, 2016, used in the 2017 Iowa Concussion Guideline Guide.

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