

MIDDLE AND HIGH SCHOOL PHYSICAL/ATHLETIC PHYSICAL EXAMINATION

ARTICLE VII 36.14 (1) PHYSICAL EXAMINATION. Every year each student 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 assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition or participate in physical education programs.

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.

Name _____ Male _____ Female _____ Birth Date _____ Grade _____

School _____ Home Address _____ Zip Code _____ Phone # _____

HEALTH HISTORY:

	YES	NO	Has this student had any?		YES	NO	Has this student had any?
1.	_____	_____	Chronic or recurrent illness or injury?	16.	_____	_____	Asthma?
2.	_____	_____	Any illnesses lasting more than one week?	17.	_____	_____	Epilepsy or other seizures?
3.	_____	_____	Rheumatic fever, mononucleosis?	18.	_____	_____	Diabetes?
4.	_____	_____	Hospitalizations (overnight or longer)?	19.	_____	_____	Eyeglasses or contact lenses?
5.	_____	_____	Surgery, other than tonsillectomy?	20.	_____	_____	Dental braces, bridges, plates?
6.	_____	_____	Missing organs (eye, kidney, testicles)?				
7.	_____	_____	Allergy to medicine, insects, food?				
8.	_____	_____	Seasonal allergies (hay fever)		YES	NO	Is there a history of?
9.	_____	_____	Problems with heart, blood pressure, cholesterol?	21.	_____	_____	Injuries requiring medical treatment?
10.	_____	_____	Racing of your heart or skipped heart beats?	22.	_____	_____	Neck injury?
11.	_____	_____	Chest pain with exercise?	23.	_____	_____	Knee injury?
12.	_____	_____	Frequent headaches, convulsions, dizziness, fainting?	24.	_____	_____	Knee surgery?
13.	_____	_____	Dizziness or fainting with exercise?	25.	_____	_____	Ankle injury?
14.	_____	_____	Concussion, unconsciousness, extremity numbness?	26.	_____	_____	Broken bones (fractures)?
15.	_____	_____	Heat exhaustion, heat stroke, or other heat related problems?	27.	_____	_____	Other serious joint injuries?
				28.	_____	_____	Use of protective equipment or braces?
	YES	NO	FURTHER HISTORY:				
29.	_____	_____	Is there a history of family or genetic disease?				
30.	_____	_____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?				
31.	_____	_____	Has any family member had a heart attack at less than 55 years of age?				
32.	_____	_____	Are you uncomfortably short of breath after running 1/2 mile (2 times around a track) without stopping?				
33.	_____	_____	List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:				

34. What is the most and least you have weighed in the past year? Most _____ Least _____

FOR WOMEN ONLY:

How old were you when you had your first menstrual period? _____ In the past year, what is the longest you have gone between menstrual periods? _____

Use this space to explain any of the above numbered YES answers or to provide additional information: _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE: I hereby give my consent to the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated on the back by the licensed professional. I also give my permission for the team's physician, athletic trainer, other qualified personnel to give first aid treatment to my son/daughter at an athletic event in case of injury.

 Typed or printed Name of Parent or Guardian

 Signature of Parent or Guardian

 Date

 Signature of Student Athlete

 Date

Name _____ Grade _____ Birth date _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed professional as designed in Article VII 36.14 (1).

IMMUNIZATION RECORD (month/date/year)

Diphtheria					
Pertussis					
Tetanus					
Polio					
Measles					
Mumps					
Rubella					
Chicken Pox					
Hep A					
Hep B					
TB Screening	Date:	Type:	Result:		

Height _____ Weight _____ Temp _____ Pulse _____ Resp _____ Blood Pressure _____

Vision R 20/ _____ L 20/ _____ Hemoglobin (optional) _____ UA (optional) _____ Other _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance (esp. Marfan's)			
Nutrition			
Development			
Hair and Scalp			
Eyes/Ears/Nose/Throat			
Mouth & Teeth			
Neck			
Lymph Nodes			
Thyroid			
Heart (standing and lying)			
Pulses (esp femoral)			
Chest and Lungs			
Abdomen			
Skin			
Genitals-Hernia			
Musculoskeletal- ROM, strength etc. (see questions 21-28)			
Speech Defect			
Neurological			

Comments regarding abnormal findings: _____

PHYSICAL EDUCATION PROGRAM/ATHLETIC PARTICIPATION RECOMMENDATION:

_____ Full and Unlimited Participation

_____ Limited Participation. **MAY NOT** participate in: _____

_____ Clearance pending documented follow up of: _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION** (reason) _____

Licensed Professional's Name (PRINTED)

Date of Examination

Licensed Professional's Signature

Phone Number

Fax Number

*Note: Physicals must be completed by a licensed physician or surgeon, a qualified doctor of chiropractic, a qualified physicians assistant or advanced registered nurse practitioner.