



# Preparticipation 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. Heart  |       |       |  |
| Have you ever passed out during or after exercise?   | _____ | _____ | _____                                      |
| Have you ever been dizzy 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?  | _____ | _____ | _____                                      |

|   | Yes   | No    | If yes, please explain (what, where, when) |
|---|-------|-------|--|
| 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?                                      | _____ | _____ | _____                                      |
| 16. 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?   | _____ | _____ | _____                                      |
| 17. Last tetnus shot?   | _____ | _____ | Date _____                                 |
| 18. Last eye exam?  | _____ | _____ | Date _____                                 |
| 19. 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,  |
| _____ Head           | _____ Heart                | _____ Hands             |
| _____ Eyes           | _____ Abdomen              | _____ Hips, Legs, Feet  |
| _____ Ears           | _____ Back                 | _____ Muscles—Strength, |
| _____ Nose           | _____ Urination,           | _____ Feeling           |
| _____ Mouth/Throat   | _____ Bowel Control        | _____ Mental, Emotional |
| _____ Nutrition,     | _____ Genital (including   | _____ Fatigue           |
| _____ Weight Control | _____ 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 \_\_\_\_\_  
 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/V \_\_\_\_\_ 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 \_\_\_\_\_ Physicians Signature \_\_\_\_\_  
 Physician's Assistant Signature\* \_\_\_\_\_  
 Advanced Nurse Practitioner 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 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 Signature Date

**IHSA Steroid Testing Policy Consent to Random Testing**

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing dietary supplements of teams and individuals qualifying for state finals competition.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at [http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA\\_banned\\_list-2007-08.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_list-2007-08.pdf).

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

