

PRE-PARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart for their records).

Date of Exam:			
Name:			Date of Birth:
Sex:	Age:	Grade:	School:
Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:			Sport(s):
Do you have any allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please identify specific allergy below:			
<input type="checkbox"/> Medicines:		<input type="checkbox"/> Pollens:	<input type="checkbox"/> Food: <input type="checkbox"/> Stinging Insects:

Explain "Yes" answers below. Circle questions you do not know the answer to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males) or spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other:			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with the doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY	Yes	No
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		
Explain "Yes" answers here:					

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.		
Signature of Athlete:	Signature of Parent(s) or Guardian:	Date:

PRE-PARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name:	Date of Birth:
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Physician Reminders:

- Consider additional questions on more sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplements?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Questions 5-14).

EXAMINATION

Height:	Weight:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No
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MEDICAL	NORMAL	ABNORMAL FINDINGS
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Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
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Eyes/Ears/Nose/Throat <ul style="list-style-type: none"> Pupils equal Hearing 		
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Lymph Nodes		
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Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal pulse (PMI) 		
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Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
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Lungs		
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Abdomen		
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Genitourinary (males only)**		
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Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 		
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Neurologic***		
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MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
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Neck		
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Back		
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Shoulder/arm		
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Elbow/forearm		
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Hip/thigh		
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Knee		
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Leg/ankle		
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Foot/toes		
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Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		
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* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam; **Consider GU exam if in private setting. Having third party present is recommended.
 ***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

<input type="checkbox"/> Cleared for all sports without restriction.
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<input type="checkbox"/> Cleared for all sports without restriction with recommendations for further evaluation or treatment for:
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<input type="checkbox"/> Not Cleared

<input type="checkbox"/> Pending further evaluation

<input type="checkbox"/> For any sports

<input type="checkbox"/> For certain sports (please list):
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Reason:

Recommendations:

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (type/print):	Date:
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Address:	Phone:
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Signature of Physician (MD/DO/ARNP/PA/Chiropractor):
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PRE-PARTICIPATION PHYSICAL EVALUATION

Missouri State High School Activity Association (MSHSAA) Eligibility and Authorization Statement

STUDENT AGREEMENT (Regarding Conditions for Participation)

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at www.mshsaa.org).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signature of Athlete:

Date:

PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)

Informed Consent: By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA- SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We authorize the release of necessary medical information to the physician, athletic trainer, and/or school personnel related to such treatment/care. We understand that the school may not provide transportation to all events, and permit / do not permit (CIRCLE ONE) my child to drive his/her vehicle in such a case.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

Name of Insurance Company:	Policy Number:
Signature of Parent(s) or Guardian:	Date:

PARENT AND STUDENT SIGNATURE (Concussion Materials)

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

Signature of Athlete:	Date:
Signature of Parent(s) or Guardian:	Date:

EMERGENCY CONTACT INFORMATION

Parent(s) or Guardian	Address	Phone Number
Name of Contact	Relationship to Athlete	Phone Number
Name of Contact	Relationship to Athlete	Phone Number

Preparticipation Sports Examination

Medical History

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the form and on back if necessary.

- | | | |
|---|-----|-----------|
| 1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor? | Yes | No |
| 2. Do you take any medication of any type? | Yes | No |
| 3. Have you ever had a severe allergic reaction to anything? | Yes | No |
| 4. Have you ever had allergic problems such as hay fever, asthma or eczema? | Yes | No |
| 5. Do you have difficult breathing or wheezing during or shortly after exercising? | Yes | No |
| 6. Have you ever had a heart murmur, racing heart or irregular heart beat? | Yes | No |
| 7. Have you ever been dizzy or passed out during exercise?* | Yes | No |
| 8. Has any family member ever had a heart attack or died suddenly before age 50? | Yes | No |
| 9. Do you have chest pain or tire more easily than others your age when exercising? | Yes | No |
| 10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out? | Yes | No |
| 11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint or persistent back/neck pain? | Yes | No |
| 12. Have you ever had a concussion or been knocked unconscious? | Yes | No |
| 13. Have you ever had a seizure? | Yes | No |
| 14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity? | Yes | No |
| 15. Is there any other medical or family history which might be important? | Yes | No |
| 16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? | Yes | No |
| 17. Have you ever required taping, padding or bracing before events or practice? | Yes | No |
| 18. Do you have damage or absence of one of any paired organs (i.e., kidney, testicle, eye, etc.)? | Yes | No |
| 19. Do you have any skin problems (rash, itching)? | Yes | No |
| 20. In the last year, how much weight have you gained or lost? _____ | | |
| 21. What is the date of your last tetanus booster? _____ | | |
| 22. What is the date of your last MMR? _____ | | |
| 23. Do you or any members of your family have a history of sickle cell trait? | Yes | No |
| | | Uncertain |

For Females Only:

- | | | |
|--|-----|----|
| 24. What is the date of your last menstrual period? _____ | | |
| 25. In the last year have you gone for three months or more without a menstrual cycle? | Yes | No |

Physical

height _____ blood pressure _____ *>140/85? _____
 weight _____ pulse _____
 vision R corrected _____ uncorrected _____
 L corrected _____ uncorrected _____
 glasses _____ contact lenses R _____ L _____ both _____
 general observations: _____
 Tanner maturity staging: _____
 HEENT: _____
 Neck: ROM _____ palpation _____ tenderness _____
 Chest: auscultation _____
 wheezing? _____ Rales? _____
 CV: heart murmur _____
 * murmur increase with valsalva? _____
 * murmur grade III or IV? _____
 * murmur diastolic? _____

rhythm _____ click _____ rub _____
 pulses: carotid _____ radial _____ pedal (DP _____ PT _____)
 edema? _____ cyanosis? _____

Abdomen _____
 * enlarged liver? _____ * enlarged spleen? _____
 hernia? _____ scars? _____
 GU: male _____ testicles R _____ L _____
 female _____
 inguinal hernia? _____
 Skin: gen. _____
 rashes _____ impetigo _____ herpes s. _____
 **MS shoulder _____
 elbow _____
 wrist/hand _____
 back _____
 hip _____
 knee _____
 ankle _____
 feet _____
 other _____

identified problems: 1 _____
 2 _____
 3 _____

recommendations coach/athletic trainer: _____

* Marfan? >2 (tall _____ striae _____ hyperextensibility _____)
 upper to lower body ratio <0.9 _____ lens dislocation _____

* requires additional evaluation
 ** detailed exam if history of injury or problem

The above named individual has been cleared for participation in the following sports:

- _____ Contact collision (football, soccer, wrestling, etc.)
- _____ Limited contact impact (baseball, basketball, volleyball)
- _____ Noncontact strenuous (track, field, running, tennis, etc.)
- _____ Noncontact moderately strenuous (badminton, table tennis)
- _____ Noncontact nonstrenuous (golf, archery, riflery)

Additional evaluation suggested:

- _____ none
- _____ coach/athletic trainer notification and clearance
- _____ physician _____
- _____ family physician _____
- _____ sports physician _____
- _____ orthopedic surgeon _____
- _____ other _____

Provider's/Physician's signature _____

Physician's Name _____ Date _____
 (Physician's name [printed] must also appear if examination is given by an Advanced Nurse Practitioner or a Certified Physician's Assistant in written collaborative practice with a physician)

(continued on reverse side)

Student Agreement Regarding Conditions for Participation:

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I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Student's signature _____ Date _____

Parent Permission and Authorization for Treatment and Release of Medical Information:

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We authorize the release of necessary medical information to the physician, athletic trainer, and/or school personnel related to such treatment/care. We understand that the school may not provide transportation to all events, and **permit / do not permit** (CIRCLE ONE) my child to drive his/her vehicle in such a case.

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year with _____
(Name of Insurance Company)

(Policy Number) Date _____

Parents or Guardian's signature _____
(All parents or guardians must sign)

_____ Date _____

To be completed by athlete or parent:

Date: _____

Name: _____
Last First Middle

Address: _____
Street

City/State Zip Phone: (_____) _____

Birthdate: _____ Age: _____ Sex: _____

Emergency Contact Person: _____

Phone: (_____) _____ Cell Phone: (_____) _____

Family Physician: _____

City/State: _____ Phone: (_____) _____

