

Physical Examination

Height _____ Weight _____ Blood Pressure _____

Pulse: resting _____ 15 hops _____ after 2 minutes resting _____

Visual Acuity: Eyes (R) 20/____ w/o glasses _____ (L) 20/____ w/glasses _____

Other Testing
1. General _____ Normal _____ Abnormal Findings _____

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 _____ 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 Steroid Testing Policy Consent to Random Testing

(This section for high school students only)

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 substances.

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_drug_classes.pdf

Signature of student-athlete _____ Date _____

Signature of parent-guardian _____ Date _____





Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name _____ Last _____ First _____ Middle _____ Sport/Position _____
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, clipped 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?			

	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?			
17. 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?	Date _____		
19. Last eye exam?	Date _____		
20. 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)

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