# 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*

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** - *May **NOT** participate in the following (checked):*

_____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** _____

**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 *(Printed)* Signature of Parent of Guardian

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.* 06/14

A FACT SHEET FOR PARENTS AND STUDENTS

# HEADS UP: Concussion in High School Sports

*Please note this important information based on Iowa Code Section 280.13C, Brain Injury Policies:*

(1) A student participating in extracurricular interscholastic activities, in grades seven through twelve, **must be immediately removed from participation** if the coach, contest official, licensed healthcare provider or emergency medical care provide believe the student has a concussion based on observed signs, symptoms, or behaviors.

(2) Once removed from participation for a suspected concussion, the **student cannot return to participation until written medical clearance has been provided** by a licensed health care provider.

(3) A student cannot return to participation until s/he is free from concussion symptoms at home and at school.

(4) Definitions:

**"Contest official"** means a referee, umpire, judge, or other official in an athletic contest who is registered with the Iowa high school athletic association or the Iowa girls high school athletic union.

**"Licensed health care provider"** means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.

**"Extracurricular interscholastic activity"** means any extracurricular interscholastic activity means any dance or cheerleading activity or extracurricular interscholastic activity, contest, or practice governed by the Iowa high school athletic association or the Iowa girls high school athletic union that is a contact or limited contact activity as identified by the American academy of pediatrics.

**"Medical clearance"** means written clearance from a licensed health care provider releasing the student following a concussion or other brain injury to return to or commence participation in any extracurricular interscholastic activity.

**What is a concussion?**

Concussions are a type of brain injury that disrupt the way the brain normally works. Concussions can occur in any sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or obstacles. Concussions can occur with or without loss of consciousness, but most concussions occur without loss of consciousness.

**What parents/guardians should do if they think their child has a concussion?**

1. Teach your child that it's not smart to play with a concussion.
2. OBEY THE LAW.
   a. Seek medical attention right away.
   b. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
3. Tell all of your child's coaches, teachers, and school nurse about ANY concussion.

**What are the signs and symptoms of concussion?**

Signs and symptoms of concussion can show up right after the injury or may not be noticed until days after the injury. If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be removed from play immediately. The athlete should only return to play with permission from a health care provider and after s/he is symptom free at home and at school.

**Signs Observed by Parents or Coaches:**

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

**Symptoms Reported by Student-Athlete:**

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

**STUDENTS,** If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

**PARENTS/GUARDIANS,** You can help your child prevent a concussion:

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

For more information visit: **www.cdc.gov/Concussion**

Athlete's Name: _____ Sex: _____

Address: _____ Grade: _____

Parent/Guardian: _____

## *ATHLETIC INSURANCE WAIVER*

All participants in MS and HS athletics must either purchase insurance made available by the school to cover the sport(s) they are going to participate in or have their own insurance that will cover the participant.

Please sign the waiver below *ONLY IF YOU DO NOT WISH TO PURCHASE THE SCHOOL'S INSURANCE*. This will tell us that you have some other form of insurance to cover your son/daughter in case of an injury.

*Waiver:* We, the undersigned parents, DO NOT wish to purchase school offered insurance to provide protection for our son or daughter in every port that he/she is going to participate in during the school year. Furthermore, we understand that there is no school insurance should our son/daughter be injured in an athletic activity for which we did not purchase such protection.

_____

Parent/Guardian Signature

## *PARENT OR LEGAL GUARDIAN PERMISSION*

By its nature, participation in interscholastic athletics includes risk of injury which may range in severity from minor to disabling to even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants can and have the responsibility to help reduce the chance of injury. Players must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

By signing the permission form, we acknowledge that we have read the above information. *PARENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THE WARNING SHOULD NOT SIGN THIS PERMISSION FORM.*

"I hereby give my consent for: _____

1. To represent his/her school in approved athletic activities except those listed: _____
2. To accompany any school team of which he/she is a member on its local or out-of-town trips.
3. To receive, through a medical doctor of the school's choice, emergency medical care which may become reasonable necessary in the course of such athletic activities or such travel.

I further agree not to hold the school or anyone acting on its behalf responsible for any injury occurring to the above name student the proper course of such athletic activities or travel.

X_____ _____

Parent/Legal Guardian Signature Date

X_____ _____

Student's Signature Date

## *"HEADS UP": CONCUSSION IN HIGH SCHOOL SPORTS*

**IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.**

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

X_____ _____

Parent/Legal Guardian Signature Date Parent/Legal Guardian Printed Name

X_____ _____

Student's Signature Date Student's Printed Name