



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, 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. 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?	_____	_____	_____

If yes, please explain (what, where, when)

	Yes	No	
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

- Smoking/smokeless tobacco _____
- Alcohol/non-medical drugs: marijuana, cocaine, etc. _____
- Steroids _____
- 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
Nose	_____	Back	_____	Muscle-Strength,
Mouth/Throat	_____	Urination,	_____	Feeling
Nutrition,	_____	Bowel Control	_____	Mental, Emotional
Weight Control	_____	Genital (including	_____	Fatigue
Neck	_____	menstrual for women)	_____	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

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	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/A	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 Substance Testing Policy Consent to Random Testing

(This section for high school students only)
2010-11 school term

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf



Signature of student-athlete _____ Date _____
 Signature of parent-guardian _____ Date _____