ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Article VII 36.14(1) Physical Exam. Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon or osteopath, qualified chiropractor, physician's assistant, or advanced registered nurse practitioner to the effect that the student has been examined and may safely engage in athletic competition.

The certificate of physical examination is valid for the purpose of this rule for one calendar year. A grace period not to exceed thirty days is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please Print)

NAME_____ MALE ____ FEMALE ____ DATE OF BIRTH _____ GRADE _____

HOME ADDRESS_____ PHONE #_____

PARENT'S NAME_____ FAMILY PHYSICIAN_____

_____ _____
Date Signature of Student

HEALTH HISTORY (Student Athlete or Parent/Guardian to Fill Out #1 - 31 Before Exam)
(Parent/Guardian is Required to Sign on Back of the Form After Examination.)

	Yes	No	Has This Student Had Any?
1.	____	____	Chronic or recurrent illness?
2.	____	____	Hospitalizations?
3.	____	____	Surgery, other than tonsillectomy?
4.	____	____	Missing organs (eye, kidney, testicle)?
5.	____	____	Allergy to medications?
6.	____	____	Problems with heart or blood pressure?
7.	____	____	Chest pain with exercise?
8.	____	____	Dizziness or fainting with exercise?
9.	____	____	Frequent headaches, convulsions, dizziness or fainting?
10.	____	____	Concussion or unconsciousness?
11.	____	____	Heat exhaustion; heat stroke, or other heat problems?
12.	____	____	Any illness lasting over a week?
13.	____	____	Rheumatic fever?

	Yes	No	Has This Student Had Any?
14.	____	____	Asthma?
15.	____	____	Epilepsy?
16.	____	____	Diabetes?
17.	____	____	Eyeglasses or contact lenses?
18.	____	____	Dental braces, bridges, plates?
	Yes	No	Is there a history of?
19.	____	____	Injuries requiring medical treatment?
20.	____	____	Neck injury?
21.	____	____	Knee injury?
22.	____	____	Knee surgery?
23.	____	____	Ankle injury?
24.	____	____	Other serious joint injury?
25.	____	____	Broken bones (fractures)?

	Yes	No	Further history:
26.	____	____	Is there any history of family or genetic disease?
27.	____	____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
28.	____	____	Has any family member had a heart attack at less than 55 years of age?
29.	____	____	Are you uncomfortably short of breath after running 1/2 mile (2 times around the track) without stopping?

30. List all medications you are presently taking and what condition the medication is for.
    A.
    B.
    C.
31. What is the most and the least you have weighed in the past year? Most _____ /Least _____

Date of last known tetanus (lockjaw) shot:_____

FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period? _____
2. In the past year, what is the longest time you have gone between menstrual periods? _____

Use this space to explain any of the above numbered YES answers or to provide any additional information:

PHYSICAL EXAMINATION RECORD (To Be Filled Out by Licensed Professional)

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name_____ Height_____Weight_____

Pulse_____ Blood Pressure_____ Hemoglobin (Optional)_____ UA (Optional)_____

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose and Throat			
3. Mouth and Teeth			
4. Neck			
5. Cardiovascular			
6. Chest and Lungs			
7. Abdomen			
8. Skin			
9. Genitals-Hernia			
10. Musculoskeletal: ROM, strength, etc.			
11. Neurological			

Comments re Abnormal Findings:_____

_____

_____

PARTICIPATION RECOMMENDATIONS

____ Full and Unlimited Participation

____ Limited Participation - May not participate in the following (checked)

_____Baseball _____Basketball _____Cheerleading _____Cross Country _____Football _____Golf _____Soccer

_____Dance Team _____Softball _____Swimming _____Track _____Volleyball _____Wrestling _____Tennis _____Weightlifting

____ No Athletic Participation

_____ _____

Licensed Professional's Name (Printed) Date

_____ _____

Signature Phone

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE (MUST BE SIGNED BEFORE STUDENT CAN PARTICIPATE)

1. I hereby give my consent for the above student to engage in approved athletic activites as a representative of his/her school, except those indicated above by the licensed professional. I understand that sports participation can involve many RISKS OF INJURY. I understand that dangers and risks of playing or practicing toplay in athletics include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of the musculo-skeletal system and serious injury or impairment to other aspects of my child's body, general health, and well-being.
2. I also give my permission for the team physician, athletic trainer, or other qualified personnel to obtain medical attention for this student at an athletic event in case of injury or illness.
3. I also understand that all students of Colfax-Mingo Schools are held acountable for their conduct by district policy. All students and parents should read the Student Code of Conduct and be aware of the policy's implication and enforcement. Students involved in activities at Colfax-Mingo are subject to the guidelines of the Code of Conduct without regard to signed verification.
4. INSURANCE: All participants in athletics must have some type of family health/accident insurance or must purchase an alternate school policy. Persons not purchasing school insurance should understand that there is no school insurance to provide protection to their child during any phase of his/her participation in athletics. Insurance information is available in the office.
   A. ____ My child is covered by a family health/accident insurance plan.
   B. ____ I will purchase the alternate health/accident policy available through Colfax-Mingo Community Schools in order to provide my child with insurance coverage.

_____ _____ _____

Typed or Printed Name of Parent or Guardian Signature of Parent or Guardian Student Signature