

MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name _____
 Home Address _____
 Parent's Name _____
 Current School _____

Male Female Grade _____ Date of Birth _____
 Phone Number _____
 Family Physician _____
 Date _____
 Student Signature _____

Explain "Yes" answers below. Circle questions to which you don't know the answer.

Yes No

1. Has a doctor ever denied or restricted your participation in sports for any reason?
 2. Do you have an ongoing medical condition (like diabetes or asthma)?
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
 4. Are you taking medicine for ADHD?
 5. Do you have allergies to medicines, pollens, foods, or stinging insects?
 6. Have you ever passed out or nearly passed out DURING exercise?
 7. Have you ever passed out or nearly passed out AFTER exercise?
 8. Have you ever had discomfort, pain, or pressure in your chest during exercise?
 9. Does your heart race or skip beats during exercise?
 10. Has a doctor ever told you that you have (circle all that apply):
 High blood pressure A heart murmur
 High cholesterol A heart infection
 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
 12. Has anyone in your family died for no apparent reason?
 13. Does anyone in your family have a heart problem?
 14. Has any family member or relative died of heart problems or of sudden death before age 50?
 15. Does anyone in your family have Marfan syndrome?
 16. Have you ever spent the night in a hospital?
 17. Have you ever had surgery?
 18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below:
 19. Have you had any broken or fractured bones, or dislocated joints?
 If yes, circle below:
 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?
 If yes, circle below:

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

21. Have you ever had a stress fracture?
 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
 23. Do you regularly use a brace or assistive device?
 24. Has a doctor ever told you that you have asthma or allergies?

Allergies: _____

Immunizations: (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella) _____

Date of last known tetanus shot: _____

Yes	No
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>
26. Is there anyone in your family who has asthma?	<input type="checkbox"/> <input type="checkbox"/>
27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> <input type="checkbox"/>
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/> <input type="checkbox"/>
29. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/> <input type="checkbox"/>
30. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/> <input type="checkbox"/>
31. Have you had a herpes skin infection?	<input type="checkbox"/> <input type="checkbox"/>
32. Have you ever had a head injury or concussion?	<input type="checkbox"/> <input type="checkbox"/>
33. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/> <input type="checkbox"/>
34. Have you ever had a seizure?	<input type="checkbox"/> <input type="checkbox"/>
35. Do you have headaches with exercise?	<input type="checkbox"/> <input type="checkbox"/>
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>
37. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>
38. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/> <input type="checkbox"/>
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/> <input type="checkbox"/>
40. Have you had any problems with your eyes or visions?	<input type="checkbox"/> <input type="checkbox"/>
41. Do you wear glasses or contact lenses?	<input type="checkbox"/> <input type="checkbox"/>
42. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/> <input type="checkbox"/>
43. Are you happy with your weight?	<input type="checkbox"/> <input type="checkbox"/>
44. Are you trying to gain or lose weight?	<input type="checkbox"/> <input type="checkbox"/>
45. Have anyone recommended you change your weight or eating habits?	<input type="checkbox"/> <input type="checkbox"/>
46. Do you limit or carefully control what you eat?	<input type="checkbox"/> <input type="checkbox"/>
47. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/> <input type="checkbox"/>

FEMALES ONLY

48. Have you ever had a menstrual period?
 49. How old were you when you had your first menstrual period? _____
 50. How many periods have you had in the last year? _____

Explain "Yes" answers here: _____

PROVIDER'S PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP: Left Arm _____ / _____ Right Arm _____ / _____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: _____

CLEARANCE

Cleared without restriction

Cleared with recommendations for further evaluation or treatment for: _____

Not cleared for All sports Certain sports _____ Reason: _____

Recommendations: _____

Name of physician/medical provider [print or type] _____ Date _____

Address _____ Phone _____

Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian _____

Signature of parent or guardian _____

Date _____

Address _____

Insurance (Company name) _____

Parent's Home Phone _____

Parent's Work Phone _____

Parent's Cell Phone _____

Additional Phone (if any-specify) _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Updated 3/10)