Physical Examination

Height _____ Weight _____ Blood Pressure _____

Pulse: resting _____ 15 hops _____ after 2 minutes _____

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/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 _____ Physicians Signature _____

STUDENT'S NAME _____

SCHOOL NAME _____

IHSA®

Illinois High School Association

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 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 Signature Date

MHSA Preparticipation Examination

To be completed by athlete or parent

Name _____ Sport/Position _____
Last First Middle

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.	Heart			
	Have you ever passed out during or after exercise?			
	Have you ever been dizzy 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?			
	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?			
16.	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?			
17.	Last tetnus shot?	Date _____		
18.	Last eye exam?	Date _____		
19.	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)

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