MIDDLE AND HIGH SCHOOL PHYSICAL/ATHLETIC PHYSICAL EXAMINATION

ARTICLE VII 36.14 (1) PHYSICAL EXAMINATION. Every year each student 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 assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition or participate in physical education programs.
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.

Name _____Male _____ Female _____ Birth Date _____ Grade _____

School _____Home Address _____ Zip Code_____Phone # _____

HEALTH HISTORY:

	YES	NO	Has this student had any?		YES	NO	Has this student had any?
1.	____	____	Chronic or recurrent illness or injury?	16.	____	____	Asthma?
2.	____	____	Any illnesses lasting more than one week?	17.	____	____	Epilepsy or other seizures?
3.	____	____	Rheumatic fever, mononucleosis?	18.	____	____	Diabetes?
4.	____	____	Hospitalizations (overnight or longer)?	19.	____	____	Eyeglasses or contact lenses?
5.	____	____	Surgery, other than tonsillectomy?	20.	____	____	Dental braces, bridges, plates?
6.	____	____	Missing organs (eye, kidney, testicles)?				
7.	____	____	Allergy to medicine, insects, food?				
8.	____	____	Seasonal allergies (hay fever)		**YES**	**NO**	**Is there a history of?**
9.	____	____	Problems with heart, blood pressure, cholesterol?	21.	____	____	Injuries requiring medical treatment?
10.	____	____	Racing of your heart or skipped heart beats?	22.	____	____	Neck injury?
11.	____	____	Chest pain with exercise?	23.	____	____	Knee injury?
12.	____	____	Frequent headaches, convulsions, dizziness, fainting?	24.	____	____	Knee surgery?
13.	____	____	Dizziness or fainting with exercise?	25.	____	____	Ankle injury?
14.	____	____	Concussion, unconsciousness, extremity numbness?	26.	____	____	Broken bones (fractures)?
15.	____	____	Heat exhaustion, heat stroke, or other heat related problems?	27.	____	____	Other serious joint injuries?
				28.	____	____	Use of protective equipment or braces?

	YES	NO	FURTHER HISTORY:
29.	____	____	Is there a history of family or genetic disease?
30.	____	____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
31.	____	____	Has any family member had a heart attack at less than 55 years of age?
32.	____	____	Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping?
33.	____	____	List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

_____
_____
_____
_____

34. What is the most and least you have weighed in the past year? Most _____ Least _____

FOR WOMEN ONLY:

How old were you when you had your first menstrual period? _____In the past year, what is the longest you have gone between menstrual periods? _____

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

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE: I hereby give my consent to the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated on the back by the licensed professional. I also give my permission for the team's physician, athletic trainer, other qualified personnel to give first aid treatment to my son/daughter at an athletic event in case of injury.

_____ _____ _____
Typed or printed Name of Parent or Guardian | Signature of Parent or Guardian | Date

_____ _____
Signature of Student Athlete | Date

Name_____ Grade_____ Birth date _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed professional as designed in Article VII 36.14 (1).

IMMUNIZATION RECORD (month/date/year)

Diptheria					
Pertussis					
Tetanus					
Polio					
Measles					
Mumps					
Rubella					
Chicken Pox					
Hep A					
Hep B					
TB Screening	Date:	Type:	Result:		

Height _____ Weight _____ Temp _____ Pulse _____ Resp _____ Blood Pressure _____

Vision R 20/ _____ L 20/ _____ Hemoglobin (optional) _____ UA (optional) _____ Other _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance (esp. Marfan's)			
Nutrition			
Development			
Hair and Scalp			
Eyes/Ears/Nose/Throat			
Mouth & Teeth			
Neck			
Lymph Nodes			
Thyroid			
Heart (standing and lying)			
Pulses (esp femoral)			
Chest and Lungs			
Abdomen			
Skin			
Genitals-Hernia			
Musculoskeletal- ROM, strength etc. (see questions 21-28			
Speech Defect			
Neurological			

Comments regarding abnormal findings: _____
_____
_____

PHYSICAL EDUCATION PROGRAM/ATHLETIC PARTICIPATION RECOMMENDATION:

_____Full and Unlimited Participation

_____ Limited Participation. **MAY NOT** participate in: _____

_____ Clearance pending documented follow up of: _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION** (reason)_____

_____ _____
Licensed Professional's Name (PRINTED) Date of Examination

_____ _____ _____
Licensed Professional's Signature Phone Number Fax Number

*Note: Physicals must be completed by a licensed physician or surgeon, a qualified doctor of chiropractic, a qualified physicians assistant or advanced registered nurse practitioner.