

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)

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?
19. Last eye exam?
20. Last Menstrual period (if women)

**Personal Habits**

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	_____	Lungs	_____	Shoulders, Arms,
Head	_____	Heart	_____	Hands
Eyes	_____	Abdomen	_____	Hips, Legs, Feet
Nose	_____	Back	_____	Muscle-Strength,
	_____	Urination,	_____	Feeling
Mouth/Throat	_____	Bowel Control	_____	Mental, Emotional
Nutrition,	_____	Genital (including	_____	
Weight Control	_____	menstrual for women)	_____	Fatigue
Neck	_____		_____	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 \_\_\_\_\_ UVI \_\_\_\_\_

% Body Fat \_\_\_\_\_ Drug Screen \_\_\_\_\_

Hgb/Hct \_\_\_\_\_ SMAC \_\_\_\_\_

\_\_\_\_\_ EKG \_\_\_\_\_

\_\_\_\_\_ Chest X-Ray \_\_\_\_\_

\_\_\_\_\_ 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 Steroid Testing Policy Consent to Random Testing**

(This section for high school students only)

In January 2009, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing substances.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at [http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA\\_Banned\\_drug\\_classes.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_Banned_drug_classes.pdf)

Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent-guardian \_\_\_\_\_ Date \_\_\_\_\_

