HIGH SCHOOL ATHLETIC PRE-PARTICIPATION EXAM FORM Circle One: IHS NHS UHS WHS

Name: _____ Grade: _____ M/F
(PRINT LEGIBLY) Last First Middle or Nickname (In Fall) Circle

Birthdate: _____ Student ID #: _____ SPORT: _____Fall _____Winter _____Spring

Section A: REQUIRED HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN

Has your child: ↓ If you answer "YES" to any questions, please explain below ↓

1.	Had a medical illness or injury that has disqualified him/her from athletic participation?	YES	NO
2.	Ever been hospitalized or undergone any surgical operations(s)?	YES	NO
3.	Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)?	YES	NO
4.	Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance?	YES	NO
5.	Ever passed out during/after exercise or become ill from exercising?	YES	NO
6.	Ever tired earlier than expected during exercise or complained of extreme fatigue?	YES	NO
7.	Ever had chest pain or unusual/irregular heartbeats during or after exercise?	YES	NO
8.	Had any history of heart problems, heart murmur, high blood pressure or high cholesterol?	YES	NO
9.	Had any family member or relative die before the age of 50 or die of heart-related problems?	YES	NO
10.	Had any family history of specific heart issues? If "YES," check all that apply:	YES	NO
	☐Hypertrophic Cardiomyopathy ☐Arrhythmia ☐Marfan's Syndrome ☐Long QT Syndrome		
11.	Had any history of concussion, head injury, loss of memory or being unconscious?	YES	NO
12.	Had any history of seizures, convulsions or fainting episodes?	YES	NO
13.	Had frequent or severe headaches?	YES	NO
14.	Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)?	YES	NO
15.	Had any problems with vision that require glasses, contacts, or protective eyewear?	YES	NO
16.	Had special protective or corrective equipment/devices that are not usually used for sports?	YES	NO
	Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids?		
17.	Been diagnosed with a contagious skin condition within the past month?	YES	NO
18.	Ever broken/fractured any bones or dislocated any joints?	YES	NO
19.	Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints?	YES	NO
20.	Is your child currently under the care of a physician for any medical, orthopedic or emotional concerns?	YES	NO
21.	Had any history of asthma, allergies to foods, medicines, or stinging insects?	YES	NO
	If "YES," what medications are used? Is Epi-Pen needed?		
22.	Does your child require any special health procedure(s) during the regular school day or during athletics?	YES	NO
23.	Is your child currently taking any prescription or "over-the-counter" medications or using an inhaler or Epi-Pen?	YES	NO

If "YES," list all medications:

Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:

If you have answered "YES" to any of the above questions, please explain: _____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Date: _____ *Signature of Parent/Guardian:* _____

Section B: PHYSICAL EXAM REQUIRED FOR ALL ATHLETES: Completed by a HEALTHCARE PROVIDER

	Normal		Normal
General:		Chest/Lungs	
Eyes, ears, nose, throat		Neck	
Cardiovascular		Abdomen	
Femoral pulses		Skin	

Visual acuity (Distance): Right: / Left: /
☐Corrected ☐Uncorrected
Height: Blood pressure:
Weight: Pulse:

Musculoskeletal:	Normal		Normal		Normal
Neck/Shoulder		Hips/Thighs		Arms/Hands	
Spine		Knees		Ankles/Feet	

Comments:

Recommendation: ☐Full activity-No restrictions ☐Activity with restrictions ☐No contact sports ☐No participation ☐Other

Examining Healthcare Provider (please print): _____

Signature: _____

DATE OF EXAM: _____ *Phone:* _____

Healthcare Provider Office Stamp:

HIGH SCHOOL ATHLETIC CONSENT FORM

Name: _____ _____ I.D.# _____ ___/___/___ GR._____ M/F
Last First Birth Date (In Fall) Circle

Parent /Guardian Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Cell Phone: ( ) _____

Address: _____

EMERGENCY CONTACT IN THE EVENT PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Relationship: ☐ Parent ☐ Guardian ☐ Step Parent ☐ Relative ☐ Friend Cell Phone: ( ) _____

Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Relationship: ☐ Parent ☐ Guardian ☐ Step Parent ☐ Relative ☐ Friend Cell Phone: ( ) _____

PLEASE READ EACH STATEMENT AND SIGN AT THE BOTTOM

I. CONSENT FOR EMERGENCY TREATMENT

Treatment Consent: In the event of an accident or emergency, I (we) give permission for the school authorities to take my (our) child to any doctor or hospital, or request their services. If not, please advise the school as to what action you would like to be taken:

_____

Athletic Trainer Consent: I give my permission to the Athletic Trainer to administer first aid, communicate with the consulting physician, and follow-up treatment and rehabilitation when appropriate in his/her professional judgment, as approved by the consulting physician.
YES OR NO

II. MEDICATION DURING ATHLETICS

My child may need medication during school hours, athletic practices, field trips, or competitions. This may include prescription medication, such as inhalers or EpiPen OR over-the-counter medication such as Advil or Tylenol. I understand that my child's physician and I, as the parent/guardian, need to complete an IUSD Parent/Guardian and Physician Request for Medication form which can be obtained from the school Health Office or www.iusd.org
YES OR NO

III. INSURANCE CERTIFICATION

I hereby certify that my child is insured for accidental death insurance in the amount of $1,500 and for at least $1,500 insurance protection for medical and hospital expenses resulting from accidental bodily injury while participating in inter-school athletic events or while being transported to and from such athletic events.
YES OR NO

Please check one of the following:
____ **My child is insured for the above activity under our family Health/Medical Plan.**

Name of Company _____ **PPO – HMO – KAISER – OTHER (circle one)**

____ **I have purchased the school insurance plan.**
____ **I am unable to purchase insurance and request additional resources from the school district.**

IV. TRANSFER ELIGIBILITY

Has student attended ANY other High School? If yes, name of school _____
YES OR NO

V. COMMUNICATION PROCEDURES

I understand that the orderly use of the following procedures is suggested when offering input to the Athletic Department, and that written documentation is recommended.

1. **Discuss needs, complaints or concerns with the Coach.**
2. **If not satisfied, request a conference with the Athletic Director.**
3. **If individual conferences with Coach and Athletic Director are not satisfying, then a conference with all parties will be held with the Assistant Principal of Athletics.**
4. **If the athlete and/or parent(s) are still not satisfied, then an appeal may be made to the Principal.**
5. **I have read and understand the Athletic Code.**

VI. PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above named student to compete in IUSD approved activity programs such as: Sports, Marching Band, Cheerleading Squad, etc. and travel with the school representative on necessary school trips. I realize that there is a risk of serious injury or death from participating in school sports and related activities. It is understood that the school district, the student body, and/or any of the employees are not financially responsible in case of accident or injury.

Date:	Signature of Parent/Guardian: