CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article III, 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 physician, a physician assistant (PA), or a nurse practitioner (NP). This certification is valid for a period of one school year.

All information is to remain confidential.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name _____ Male _____ Female _____ Date of Birth _____ Grade _____

Home Address _____ Phone Number _____

Parent's Name _____ Family Physician _____

Current School _____

_____ _____

Date Student's Signature

Health History (Student athlete or parent/guardian to fill out one through thirty-three before exam)
(Parent/Guardian is required to sign on the back of the form after the examination.)

	Yes	No	Has this student had any:
1.	_____	_____	Chronic or recurrent illness
2.	_____	_____	Hospitalizations
3.	_____	_____	Surgery, other than tonsillectomy
4.	_____	_____	Missing organs (eye, kidney, testicle)
5.	_____	_____	Allergy to medications
6.	_____	_____	Problems with heart or blood pressure
7.	_____	_____	Chest pain with exercise
8.	_____	_____	Have you ever been told you have a heart murmur
9.	_____	_____	Dizziness or fainting with exercise
10.	_____	_____	Frequent headaches, convulsions, dizziness or fainting
11.	_____	_____	Concussion or unconsciousness
12.	_____	_____	Heat exhaustion, heat stroke or other heat problems
13.	_____	_____	Any illness lasting over a week
14.	_____	_____	Mononucleosis or anemia
15.	_____	_____	Bladder/kidney infections in the past year

	Yes	No	Has this student had any:
16.	_____	_____	Asthma
17.	_____	_____	Epilepsy
18.	_____	_____	Diabetes
19.	_____	_____	Eyeglasses or contact lenses
20.	_____	_____	Dental braces, bridges, plates

	Yes	No	Is there a history of:
21.	_____	_____	Injuries requiring medical treatment
22.	_____	_____	Neck injury
23.	_____	_____	Knee injury
24.	_____	_____	Knee surgery
25.	_____	_____	Ankle injury
26.	_____	_____	Other serious joint injury
27.	_____	_____	Broken bones (fractures)

	Yes	No	Further History:
28.	_____	_____	Is there any history of family or genetic diseases?
29.	_____	_____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
30.	_____	_____	Has any family member had a heart attack at less than 55 years of age?
31.	_____	_____	Are you uncomfortably short of breath after running ½ mile (two times around the track) without stopping?

32. List all medications you are presently taking and what condition the medication is for:
    A.
    B.
    C.
33. How old were you when you had your first menstrual period? _____
34. In the past year, what is the longest time you have gone between menstrual periods? _____
35. What is the most and the least you have weighed in the past year? Most _____ Least _____
36. Have you had a medical problem/injury since your last physical where you missed three or more practices? _____
37. Do you have any questions you would like to ask the Doctor? _____

Date of last known tetanus (lockjaw) shot: _____

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

PHYSICAL EXAMINATION RECORD (to be completed by a Licensed Professional)

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____ Hemoglobin (optional) _____ UA (optional) _____

	Normal	Abnormal Findings	Initials
1. Eyes Left /20 Right /20 Pupils			
2. Ears, nose and throat			
3. Mouth and teeth			
4. Neck			
5. Cardiovascular			
6. Chest and lungs			
7. Abdomen			
8. Skin			
9. Genitals-Hernia			
10. Musculoskeletal: ROM, strength etc.			
11. Neurological			

Comments regarding abnormal findings/recommendations:

Participation Recommendations

_____ Full and unlimited participation

_____ Limited participation – may not participate in the following (check all that apply):

_____Basketball
_____Cross Country
_____Football
_____Golf
_____Soccer
_____Softball
_____Swimming
_____Tennis
_____Track
_____Volleyball
_____Wrestling

_____ Clearance pending documented follow-up of:

_____ No athletic participation

_____ _____
Date Licensed Professional's Name (Print)

_____ _____
Phone Number Signature

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

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 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 Phone Number

_____
Insurance (Company name)

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(Revised 05/03)