

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 _____

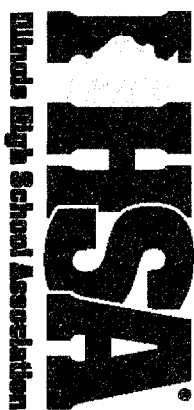
Physician's Assistant Signature* _____

Advanced Nurse Practitioner 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 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 _____

MUST BE STAMPED BY PHYSICIAN TO BE VALID. PLACE STAMP HERE

I HSA 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. _____ City/State _____
 Family Doctor _____
 Phone No. _____

Past Medical History

Yes No If yes, please explain (what, where, when)

- Presently taking medication (including birth control pills)?
- Have you been diagnosed with asthma?
- Have you been prescribed by a physician to use any asthma medication?
- Do you have a current consent form to self-administer the asthma medication on file with your school?
- Allergic to medicine, foods, bee stings?
- Wears any appliances—glasses, contact lenses?
- History of braces, chipped teeth, bridges?
- Has ongoing medical problem?
- Had serious or significant illness in past?
- Any past surgical operations, accidents, non-sports or related injuries?
- Any past injuries directly related to sports?
- Any hospitalization not explained above?
- Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?
- Any serious family illness (such as diabetes, bleeding disorders, etc.)?
- 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?

Yes No If yes, please explain (what, where, when)

- 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?
- 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?
- Last tetanus shot?
- Last eye exam?
- Last menstrual period (if women)

Personal Habits

- Smoking/smokeless tobacco
- Alcohol/non-medical drugs: marijuana, cocaine, etc
- Steroids
- 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
Ears	Back	Muscles—Strength,
Nose	Urination,	Feeling
Mouth/Throat	Bowel Control	Mental, Emotional
Nutrition,	Genital (including menstrual for women)	Fatigue
Weight Control	Other: What?	
Neck		

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