IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____

Date of Examination: _____ Sport(s): _____

Home Address (Street, City, Zip): _____ School District: _____

Parent's/Guardian's Name: _____ Phone #: _____

Physician: _____ Phone #: _____

History Form:

List past and current medical conditions.

_____

Have you ever had a surgery? If "yes", list all past surgical procedures.

_____

Medicines and Supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (to medicines, pollen, food, stinging insects, etc.)

_____

PHQ-4: Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response)

	Not at all	Several Days	Over half the days	Nearly Everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [Questions 1 and 2, or Questions 3 and 4] for screening purposes)

SCORE: _____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

General Questions:

Y N

☐ ☐ Do you have any concerns that you would like to discuss with your provider?

☐ ☐ Has a provider ever denied or restricted your participation in sport for any reason?

☐ ☐ Do you have any ongoing medical issues or recent illnesses?

Heart Health Questions:

Y N

☐ ☐ Have you ever passed out of nearly passed out during or after exercise?

☐ ☐ Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?

☐ ☐ Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?

☐ ☐ Has a doctor ever told you that you have any heart problems?

☐ ☐ Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?

☐ ☐ Do you get lightheaded or feel shorter of breath than your friends during exercise?

☐ ☐ Do you have high blood pressure or high cholesterol?

Questions about your Family:

Y	N	
☐	☐	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
☐	☐	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
☐	☐	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
☐	☐	Does anyone in your family have asthma?

Bone and Joint Questions:

Y	N	
☐	☐	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?
☐	☐	Have you had an X-ray, MRI, CT scan or physical therapy for any reason?
☐	☐	Do you have a bone, muscle, ligament or joint injury that bothers you?
☐	☐	Do you currently, or have you in the past worn orthotics, braces or protective equipment for any reason?

Medical Question:

Y	N	
☐	☐	Do you cough, wheeze or have difficulty breathing during or after exercise?
☐	☐	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
☐	☐	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
☐	☐	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?
☐	☐	Have you had a concussion? Or a head injury that caused confusion, a prolonged headache, or memory problems?
☐	☐	Have you ever had a seizure?
☐	☐	Do you get frequent headaches?
☐	☐	Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?
☐	☐	Have you ever become ill when exercising in the heat?
☐	☐	Do you have sickle cell trait or disease? Or anyone in your family?
☐	☐	Have you ever had or do you have any problems with your eyes or vision?
☐	☐	Do you worry about your weight?
☐	☐	Are you trying to or has anyone recommended that you gain or lose weight?
☐	☐	Are you on a special diet or do you avoid certain types of foods or food groups?
☐	☐	Have you ever had an eating disorder?

FEMALES only:

Y	N	
☐	☐	Have you ever had a menstrual period?
☐	☐	How old were you when you had your first menstrual period?
☐	☐	When was your most recent menstrual period?
☐	☐	How many periods have you had in the last 12 months?

EXPLAIN "Yes" answers here:

_____

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

Signature of Athlete: _____

Signature of Parent or Guardian: _____ Date: _____

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y N

☐ ☐ Do you feel stressed out or under a lot of pressure?
☐ ☐ Do you ever feel sad, hopeless, depressed or anxious?
☐ ☐ Do you feel safe at your home or residence?
☐ ☐ Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?
☐ ☐ Do you drink alcohol or use any other drugs?
☐ ☐ Have you taken prescriptions medications that were not yours or outside of their intended use?
☐ ☐ Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
☐ ☐ Have you ever taken any supplements to help you gain or lose weight or improve your performance?
☐ ☐ Do you wear a seat belt and a helmet?
☐ ☐ Do you use condoms if you are sexually active?

EXAMINATION

Height: _____ Weight: _____

BP: _____ / _____ (____/____) Pulse: _____ Vision: R 20/____ L 20/____ Corrected Y / N

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal & Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test		

- Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings or a combination of those.

Medical Eligibility Form

Student Athlete Name: _____ Date of Birth: _____ Date of Examination: _____

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible.

Signature of Parent or Guardian: _____ Date: _____

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:

_____

Medications:

_____

Other Information:

_____

Emergency Contacts:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

Participation Eligibility *(To be filled out by medical provider)*

☐ Medically Eligible for sports without restriction.

☐ Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:

_____

☐ Medically eligible for certain sports:

_____

☐ Not medically eligible pending further evaluation

_____

☐ Not medically eligible for any sports

Recommendations:

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional:

_____

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

(1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
(2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
(3) Key definitions:
"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
"Extracurricular interscholastic activity" means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?
A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?
1. OBEY THE NEW LAW.
   a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
   b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?
You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:
If you think you have a concussion:
- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

Signs Reported by Students:
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

PARENTS:
How can you help your child prevent a concussion?
Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.
- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs Observed by Parents or Guardians:
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.
For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature	Date	Student's Printed Name	
Parent's/Guardian's Signature	Date	Student's School	