PRE-PARTICIPATION EXAMINATION FORM

Instructions for completing pre-participation (athletic)
Health Examination and Consent Form

COMPLETING THIS FORM:

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination must be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

_____ _____
Name of Student *School*

Is the student covered by health/accident insurance? ❑Yes ❑No

_____
Name of health insurance provider

If no insurance provider, explain _____

_____

_____

_____

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. *http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf*

_____ _____
Parent or Guardian Name *Parent or Guardian Signature*

_____
Date

Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

_____ _____
Signature of Student *Date*

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

*Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest*

ATHLETE INFORMATION

Athlete Name: _____ **Date of Exam:** _____

Sport(s): _____

Birth date: _____ **Age:** _____ **Grade in school** _____ **Gender:** _____ **School year:** _____

Athlete Cell Phone No. (_____) _____ **Athlete Address:** _____

EXAMINATION: TO BE FILLED OUT BY PHYSICIAN ONLY

Height: _____ Weight: _____ ☐ Male ☐ Female

Pulse: _____ BP: _____/_____ % Body Fat (opt) _____

Vision: Left_____/_____Right_____/_____ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

Immunizations: Tetanus _____ MMR _____ Hep B _____ Chickenpox_____

GENERAL MEDICAL (please initial)	Normal	Abnormal Findings	MUSCULOSKELETAL (please initial)	Normal	Abnormal Findings
Appearance (Marfan stigmata)			Neck		
Eyes/Ears/Nose/Throat (Pupils Equal, Hearing)			Back		
Lymph Nodes			Shoulder/ Arm		
Heart (murmurs)			Elbow/ Forearm		
Pulses (Simultaneous femoral and radial pulses)			Wrist/ Hand/ Fingers		
Lungs			Hip/ Thigh		
Abdomen			Knee		
Skin (HSV, MRSA, tinea corporis)			Leg/ Ankle		
Neurological			Foot/ Toes		
Genitourinary (males only)			Functional (Duck walk, single leg hop)		

ATHLETIC PARTICIPATION RECOMMENDATIONS *(Physician MUST select one item listed below)*

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION**—May NOT participate in the following _____

_____ **CLEARED PENDING**—Documented follow up of: _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

Physician's Comments: _____

_____

_____

Physician's Name: _____
(Please print)
Physician Signature: _____ Date: _____

IF THIS FORM IS NOT FULLY COMPLETED INCLUDING DOCTOR ADDRESS AND NUMBER, IT WILL NOT BE ACCEPTED

Physician's Office Address

Telephone: (____) _____

ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

*Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest*

Athlete Name: _____ **Date of Birth**_____

MEDICAL HISTORY

Medicines: Please list all of the prescription and over-the-counter medicine and supplements (herbal and nutritional) that you are currently taking

_____

Allergies: Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy.

☐ Medicines_____ ☐ Pollens _____ ☐ Food _____ ☐ Stinging Insects_____

ANY "YES" RESPONSES MUST BE EXPLAINED IN FULL AFTER EACH QUESTION IN THE SPACE

GENERAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:		
Have you ever spent the night in the hospital?		
Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
Have you ever passed out or 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 or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? If so check all that Apply: ☐ High Blood Pressure ☐ High Cholesterol ☐ Kawasaki Disease ☐ A heart murmur ☐ A heart infection ☐ Other: _____		
Has a doctor ever ordered a test for your heart? (e.g. ECG/EKG, Echocardiogram)?		
Do you get light headed or feel more short of breath than expected during exercise?		
Have you ever had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
Has any family member or relative died of a heart problem or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
Does anyone in your family have hypertrophic cardiomyopathy, Long QT syndrome, Short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
Does anyone in your family have a heart problem, pacemaker, or implanted Defibrillator?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
Have you ever had an injury to a bone, muscle , ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken, fractured or dislocated bones?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Have you ever had a stress fracture?		
Have you ever been told that you have or have you had an x-ray for a neck instability or atlantoaxial instability (down syndrome or dwarfism)?		
Do you regularly use a brace, orthotics, or other assistive devices?		
Do you have a bone, muscle, or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis, or connective tissue disease?		
Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? *Specify below if yes*		
If yes, check the appropriate box and explain below: ☐ Head _____ ☐ Neck _____ ☐ Back _____ ☐ Shoulder _____ ☐ Arm _____ ☐ Elbow _____ ☐ Finger _____ ☐ Wrist _____ ☐Hand _____ ☐ Shin/Calf _____ ☐Thigh _____☐ Knee _____ ☐Hip _____☐Ankle _____ ☐Foot _____		

MEDICAL QUESTIONS	Yes	No
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medication?		
Is there anyone in your family who has asthma?		
Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores, or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have a history of seizure disorder?		
Have you had any problems with your eyes or vision?		
Have you had any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eye wear such as goggles, or a face shield?		
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?		
Have you ever had an eating disorder?		
HEAT ILLNESS QUESTIONS	Yes	No
Have you ever become ill while exercising in the heat?		
Do you get frequent muscle cramps when exercising?		
Do you or someone in your family have sickle cell trait or disease?		
HEAD AND NECK HEALTH QUESTIONS	Yes	No
Do you have headaches with exercise?		
Have you ever had a head injury or concussion?		
Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness , tingling, or weakness in your arms of legs after being hit or falling?		
Have you ever been unable to move your arms or legs after being hit or falling?		
FEMALES ONLY		
When was your first menstrual period (age when started)?		
When was your most recent menstrual period?		
How much time do you usually have from the start of one period to the start of another?		
How many periods have you had in the last year?		
What was the longest time between periods in the last year?		

Parent Signature: _____ Date: _____