



## HEALTH EXAMINATION *and* CONSENT FORM

It is required all students complete a history and physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the school administration prior to the first practice.

Name: \_\_\_\_\_ Sex: M / F Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ Sports: \_\_\_\_\_ Participation Grade: \_\_\_\_\_

### MEDICAL HISTORY

- Fill in details of "YES" answers in space below:
- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized?<br>Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever had a head injury?<br>Have you ever been knocked out or unconscious?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medication or pills?  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with a concussion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, other insects)?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you tire more quickly than your friends during exercise?<br>Have you ever had high blood pressure?<br>Have you been told you have a heart murmur?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever had heat or muscle cramps?<br>Have you ever been dizzy or passed out in the heat?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rash, acne)?   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have trouble breathing or do you cough during or after exercise?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc.)?                     | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 10. Have you ever had problems with your eyes or vision?<br>Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 11. Have you had any other medical problems (infectious mononucleosis, diabetes, ect.)?                          | <input type="checkbox"/> | <input type="checkbox"/> |
12. Have you had a medical problem or injury since your last evaluation?  Yes  No
13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?  
 head  back  shoulder  forearm  hand  hip  knee  ankle  
 neck  chest  elbow  wrist  finger  thigh  shin  foot
14. Were you born without a kidney, testicle, or any other organ?  Yes  No
15. When was your first menstrual period? \_\_\_\_\_  
 When was your last menstrual period? \_\_\_\_\_  
 What was the longest time between your periods last year? \_\_\_\_\_

Explain "YES" answers: \_\_\_\_\_

### CONSENT FORM

(Parent or guardian and student permission and approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

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 regulation of the State Association.

SIGNATURE OF STUDENT \_\_\_\_\_ DATE: \_\_\_\_\_

# Idaho High School Activities Association

## Physical Examination Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height _____ Weight _____ BP _____ / _____ Pulse _____ Vision R 20 / _____ L 20 / _____ Corrected: Y N		
	<b>Normal</b>	<b>Abnormal findings</b>
<b>Medical</b>		
Pulses		
Heart		
Lungs		
Skin		
Ears, nose, throat		
Abdomen		
Genitalia (males)		
<b>Musculoskeletal</b>		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

### CLEARANCE / RECOMMENDATIONS

Clearance:

- A. Cleared for all sports and other school-sponsored activities.
- B. Cleared after completing evaluation/rehabilitation for:  
\_\_\_\_\_
- C. NOT cleared to participate in the following IHSAA sponsored sports /activities:  
 baseball    basketball    cheer/dance    cross country    football    golf  
 soccer    softball    swimming    tennis    track    volleyball    wrestling  
NOT cleared for other school-sponsored activities (*example: lacrosse*):  
 \_\_\_\_\_
- D. Student is NOT permitted to participate in high school athletics.

Reason: \_\_\_\_\_

Recommendation:

Name of physician:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician/medical provider: \_\_\_\_\_ Date: \_\_\_\_\_

(This Physical Examination Form MUST be signed by a licensed physician, physician assistant or nurse practitioner)