

PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.

Every year each student (grades 7-12) shall present to the student's

superintendent a certificate signed by a licensed physician and surgeon; osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or print this information)

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

Home Address _____ Phone # _____

Parent's/Guardian's Name _____ Date _____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the back of this form after the physical examination is completed.)

Yes No Has this student had any?

- _____ Chronic or recurrent illness or injury?
- _____ Any illness lasting more than one (1) week?
- _____ Rheumatic fever, mononucleosis?
- _____ Hospitalizations (Overnight or longer)?
- _____ Surgery, other than tonsillectomy?
- _____ Missing organs (eye, kidney, testicle)?
- _____ Allergy to medications, insects, food?
- _____ Seasonal allergies (hay fever)?
- _____ Problems with heart, blood pressure, cholesterol?
- _____ Racing of your heart or skipped heart beats?
- _____ Chest pain with exercise?
- _____ Frequent headaches, convulsions, dizziness, fainting?
- _____ Dizziness or fainting with exercise?
- _____ Concussion, unconsciousness, extremity numbness?
- _____ Heat exhaustion, heat stroke, or other heat related problems?

Yes No Has this student had any?

- 15. _____ Asthma?
- 16. _____ Epilepsy or other seizures?
- 17. _____ Diabetes?
- 18. _____ Eyeglasses or contact lenses?
- 19. _____ Dental braces, bridges, plates?

Yes No Is there a history of?

- 20. _____ Injuries requiring medical treatment?
- 21. _____ Neck injury?
- 22. _____ Knee injury?
- 23. _____ Knee surgery?
- 24. _____ Ankle injury?
- 25. _____ Broken bones (fractures)?
- 26. _____ Other serious joint injuries?
- 27. _____ Use of protective equipment or braces?

Yes No Further History:

- 1. _____ Is there a history of family or genetic disease?
- 1. _____ Has any family member died suddenly at less than 40 years of age of causes other than an accident?
- 1. _____ Has any family member had a heart attack at less than 55 years of age?
- _____ Are you uncomfortably short of breath after running 1/2 mile (2 times around a track) without stopping?
- _____ List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A.
B.
C.

- 1. What is the most and least you have weighed in the past year? Most _____ Least _____
Date of last known tetanus (lockjaw) shot: _____

FOR WOMEN ONLY:

- How old were you when you had your first menstrual period? _____
- In the past year, what is the longest time you have gone between menstrual periods? _____

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

PHYSICAL EXAMINATION RECORD (To be completed by a licensed professional. This valuation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.)

athlete's Name _____
 Height _____ Weight _____ Pulse _____ Blood Pressure _____ Vision R 20/ _____ L 20/ _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance (esp. Marfan's)			
Eyes/Ears/Nose/Throat			
Mouth & Teeth			
Neck			
Lymph Nodes			
Heart (Standing & Lying)			
Pulses (esp. femoral)			
Chest & Lungs			
Abdomen			
0. Skin			
1. Genitals - Hernia			
2. Musculoskeletal - ROM, strength, etc. (See questions 20-27)			
3. Neurological			

Comments regarding abnormal findings: _____

ATHLETIC PARTICIPATION RECOMMENDATIONS:

Full & Unlimited Participation

Limited Participation - May NOT participate in the following (checked):

Baseball Basketball Cross Country Football Golf Soccer
 Softball Swimming Tennis Track Volleyball Wrestling

Clearance Pending Documented Follow up of _____

NOT CLEARED FOR ATHLETIC PARTICIPATION

Licensed Professional's Name (Printed) _____ Date _____

Licensed Professional's Signature _____ Phone _____

Parent's or Guardian's Permission and Release (Sign after the physical examination has been completed.)
 I hereby give my consent for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also give my permission for the team's physician, athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

Typed or printed Name of Parent or Guardian _____ Signature of Parent of Guardian _____

Address (Street/PO Box, City, State, Zip) _____ Phone Number _____

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 annually 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 Grade

Student's School

Revised August, 1989

SOUTH HAMILTON COMMUNITY SCHOOL
JEWELL, IOWA 50130

Certification of Insurance and Injury Warning

I realize that there is the inherent possibility of injury anytime a student participates in an athletic activity of any kind. I give my permission for (student's name) _____ to participate in the athletic programs at the South Hamilton School.

We have insurance protection with _____ that will protect the above named student for medical, hospital, and other expenses which may result from injuries sustained in athletic competition.

Date _____

Signed _____

Parent/Guardian

**HEALTH AND INJURY INFORMATION CARD and
CONSENT FOR MEDICAL TREATMENT FORM**

*This form is to be completed and kept available for reference wherever competition takes place.
Update medical information as necessary.*

Student's Name (Last, First, MI) _____

Age _____ Grade _____ Date of Birth _____ Today's Date _____

Student ID# _____

Parent/Guardian Name(s) _____

Student Address _____

Parent/Guardian Home Phone Number(s) _____

Parent/Guardian Place(s) of Work _____

Parent/Guardian Work Phone Number(s) _____

In an emergency, when parent/guardian cannot be notified, please contact:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Preferred Hospital _____ Phone _____

Family Dentist _____ Phone _____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses ___yes ___no / Contacts ___yes ___no / Dentures ___yes ___no

- OVER PLEASE -

0599

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.)

Please note and date any new injury information here: _____

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. This written authorization is granted only after a reasonable effort has been made to contact me (us).

Date

Parent's/Guardian's signature

Consent for Treatment endorsed by

the Iowa Chapter of the American Academy of Emergency Physicians

Cards provided by

THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE, IA