PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. Every year each student (grades 7-12) shall present to the student's perintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced gistered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic*, to the effect that the student has been amined and may safely engage in athletic competition.

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

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

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

me Address _____ Phone # _____

rent's/Guardian's Name _____ Date _____

mily Physician _____ Phone # _____

:ALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or ardian. ***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:*
_____	_____	Is there a history of family or genetic disease?
_____	_____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
_____	_____	Has any family member had a heart attack at less than 55 years of age?
_____	_____	Are you uncomfortably short of breath after running ½ 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.

What is the most and least you have weighed in the past year? Most _____ Least _____

Date of last known tetanus (lockjaw) shot: _____

R WOMEN ONLY:

low old were you when you had your first menstrual period? _____

n the past year, what is the longest time you have gone between menstrual periods? _____

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

_____

_____

_____

valuation is only to determine readiness for sports participation. It should not be used as a substitute for regular health aintenance examinations.

thlete's Name _____

eight _____ 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, rength, etc. *(See questions 20-27)*			
3. Neurological			

omments regarding abnormal findings: _____

THLETIC 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**

_____ _____

icensed Professional's Name (Printed) Date

_____ _____

icensed Professional's Signature Phone

Parent's or Guardian's Permission and Release **(Sign after the physical examination has been completed.)**

hereby give my consent for the above named student to engage in approved athletic activities as a representative of his/her school, xcept those activities indicated above by the licensed professional. I also give my permission for the team's physician, athletic trainer, r other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

_____ _____

yped or printed Name of Parent or Guardian Signature of Parent of Guardian

_____ _____

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

his form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use y the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. 8/00

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 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 -

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