

# Mason City Community School District

## PHYSICAL EXAMINATION

Article VII 36.14 (1) Physical Exam. 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, qualified chiropractor, physician's assistant, or advanced registered nurse practitioner 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 Print)

NAME \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_ GRADE \_\_\_\_\_

\_\_\_\_\_  
Signature of Student \_\_\_\_\_ Date \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

HEALTH HISTORY (Student Athlete or Parent/Guardian to Fill Out #1-35 Before Exam)  
(Parent/Guardian is Required to Sign on Back of the Form After Examination.)

- | YES        | NO        | Has This Student Had Any?   | YES        | NO        | Has This Student Had Any?              |
|------------|-----------|---|------------|-----------|--|
| 1. ___     | ___       | Chronic or recurrent illness or injury?   | 16. ___    | ___       | Asthma?                                |
| 2. ___     | ___       | Any illness lasting more than one (1) week?   | 17. ___    | ___       | Epilepsy or other seizures?            |
| 3. ___     | ___       | Rheumatic fever, mononucleosis?   | 18. ___    | ___       | Diabetes?                              |
| 4. ___     | ___       | Hospitalizations (Overnight or longer)?   | 19. ___    | ___       | Eyeglasses or contact lenses?          |
| 5. ___     | ___       | Surgery, other than tonsillectomy?  | 20. ___    | ___       | Dental braces, bridges, plates?        |
| 6. ___     | ___       | Missing organs (eye, kidney, testicle)?   |            |           |  |
| 7. ___     | ___       | Allergy to medications, insects, food?  |            |           |  |
| 8. ___     | ___       | Seasonal allergies (hay fever)?   | <b>YES</b> | <b>NO</b> | <b>Is There A History Of?</b>          |
| 9. ___     | ___       | Problems with heart, blood pressure, cholesterol?   | 21. ___    | ___       | Injuries requiring medical treatment?  |
| 10. ___    | ___       | Racing of your heart or skipped heart beats?  | 22. ___    | ___       | Neck injury?                           |
| 11. ___    | ___       | Chest pain with exercise?   | 23. ___    | ___       | Knee injury?                           |
| 12. ___    | ___       | Frequent headaches, convulsions, dizziness, fainting?   | 24. ___    | ___       | Knee surgery?                          |
| 13. ___    | ___       | Dizziness or fainting with exercise?  | 25. ___    | ___       | Ankle injury?                          |
| 14. ___    | ___       | Concussion, unconsciousness, extremity numbness?  | 26. ___    | ___       | Broken bones (fractures)?              |
| 15. ___    | ___       | Heat exhaustion, heat stroke, or other heat related problems?   | 27. ___    | ___       | Other serious joint injuries?          |
|            |           |   | 28. ___    | ___       | Use of protective equipment or braces? |
| <b>YES</b> | <b>NO</b> | <b>Further History:</b>   |            |           |  |
| 29. ___    | ___       | Is there any history of family or genetic disease?  |            |           |  |
| 30. ___    | ___       | Has any family member died suddenly at less than 40 years of age other than an accident?                |            |           |  |
| 31. ___    | ___       | Has any family member had a stroke at less than 55 years of age?  |            |           |  |
| 32. ___    | ___       | Are you uncomfortably short of breath after running 1/2 mile (2 times around a track) without stopping? |            |           |  |

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

33. List all medications you are presently taking and what condition the medication is for.

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

34. Date of last known tetanus (lockjaw) vaccination: \_\_\_\_\_ Meningitis vaccination: \_\_\_\_\_ HBV vaccination: \_\_\_\_\_

35. What is the most and the least you have weighed in the past year? **Most** \_\_\_\_\_ **Least** \_\_\_\_\_

### FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period: \_\_\_\_\_

2. In the past year, what is the longest time you have gone between menstrual periods? \_\_\_\_\_

**PHYSICAL EXAMINATION RECORD** (To Be completed by a licensed medical professional as designated in Article VII 36.14 (1). *This evaluation 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/\_\_\_\_ Vision corrected? Yes \_\_\_\_\_ No \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Mouth & Teeth			
4. Neck			
5. Lymph Nodes			
6. Heart (Standing & Lying)			
7. Pulses (esp. femoral)			
8. Chest & Lungs			
9. Abdomen			
10. Skin			
11. Genitals – Hernia			
12. Musculoskeletal – ROM, strength, etc. (See questions 21-28)			
13. Neurological			

Comments regarding abnormal findings:

\_\_\_\_\_  
\_\_\_\_\_

**LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS**

\_\_\_\_\_ **FULL & UNLIMITED PARTICIPATION**

\_\_\_\_\_ **LIMITED PARTICIPATION** - May NOT participate in the following (checked):

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

\_\_\_\_\_ **CLEARANCE PENDING DOCUMENTED FOLLOW UP**

\_\_\_\_\_ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

\_\_\_\_\_ Licensed Medical Professional's Name (Printed)

\_\_\_\_\_ Date

\_\_\_\_\_ Licensed Medical Professional's Signature

\_\_\_\_\_ Phone

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I hereby **verify** the accuracy of the information on the opposite side of this form and **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, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

**Check 1 of the following 2 choices: (Students MUST be covered by insurance before being allowed to participate.)**

Check One: \_\_\_\_\_ I, the undersigned, feel I have adequate insurance protection for my son/daughter while practicing or participating in Interscholastic Sports, or other school sponsored activities.

\_\_\_\_\_ I will purchase the alternate health/accident policy available through the Mason City Community Schools.

\_\_\_\_\_ Typed or printed Name of Parent/Guardian

\_\_\_\_\_ Signature of Parent/Guardian

\_\_\_\_\_ Date