



## 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?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | 6. Have you ever had a head injury?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | 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?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | Have you ever had a stinger, burned or pinched nerve?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | 7. Have you ever had heat or muscle cramps?                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | Have you ever been dizzy or passed out in the heat?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | 8. Do you have trouble breathing or do you cough during or |                          |                          |
| Have you ever had high blood pressure?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been told you have a heart murmur?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | 9. Do you use special equipment (pads, braces, neck rolls, |                          |                          |
| Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/>                                 | <input type="checkbox"/> | mouth guard or eye guards, etc.)?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden   |  |                          | 10. Have you ever had problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| death before age 50?   | <input type="checkbox"/>                                 | <input type="checkbox"/> | Do you wear glasses, contacts or protective eyewear?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rash, acne)?  | <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?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |  |                          |                          |
| 13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of bones or joints?   |  |                          |  |                          |                          |
| <input type="checkbox"/> head <input type="checkbox"/> back <input type="checkbox"/> shoulder <input type="checkbox"/> forearm <input type="checkbox"/> hand <input type="checkbox"/> hip <input type="checkbox"/> knee <input type="checkbox"/> ankle |  |                          |  |                          |                          |
| <input type="checkbox"/> neck <input type="checkbox"/> chest <input type="checkbox"/> elbow <input type="checkbox"/> wrist <input type="checkbox"/> finger <input type="checkbox"/> thigh <input type="checkbox"/> shin <input type="checkbox"/> foot  |  |                          |  |                          |                          |
| 14. Were you born without a kidney, testicle, or any other organ?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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	
Normal	Abnormal findings		
<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)