IHSA ILLINOIS HIGH SCHOOL ASSOCIATION IESA

Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name____ Sport/Position_______________
Last First Middle

Social Security Number__________________________ School Year_______________

Address____

City/State___________________________________ Phone No._______________

Birthdate_______________ Age______ Class_______ Student ID No._______________

Parent's Name____

Address____

Phone No.____________________________

Person to contact in case of emergency________________________________

Phone No.____________________________

Family Doctor_________________________________ City/State_______________

Phone No.____________________________

Past Medical History

		Yes	No	If yes, please explain (what, where, when)
1.	Presently taking medication (including birth control pills)?	___	___	___
2.	Have you been diagnosed with asthma?	___	___	___
3.	Have you been prescribed by a physician to use any asthma medication?	___	___	___
4.	Do you have a current consent form to self-administer the asthma medication on file with your school?	___	___	___
5.	Allergic to medicine, foods, bee stings?	___	___	___
6.	Wears any appliances – glasses, contact lenses?	___	___	___
7.	History of braces, chipped teeth, bridges?	___	___	___
8.	Has ongoing medical problem?	___	___	___
9.	Had serious or significant illness in past?	___	___	___
10.	Any past surgical operations, accidents, non-sports or related injuries?	___	___	___
11.	Any past injuries directly related to sports?	___	___	___
12.	Any hospitalization not explained above?	___	___	___
13.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?	___	___	___
14.	Any serious family illness (such as diabetes, bleeding disorders, etc.)?	___	___	___
15.	Family history of cancer?	___	___	___
16.	Heart			
	Have you ever passed out during or after exercise?	___	___	___
	Have you ever had chest pain during or after exercise?	___	___	___
	Do you get tired more quickly than your friends do during exercise?	___	___	___
	Have you ever had racing of your heart or skipped heartbeats?	___	___	___
	Have you had high blood pressure or high cholesterol?	___	___	___
	Have you ever been told you have a heart murmur?	___	___	___
	Has any family member or relative died of heart problems or of sudden death before age 50?	___	___	___
	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	___	___	___
	Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	___
	Has anyone in your family had a heart attack before the age of 50?	___	___	___
17.	Head and Nerve	___	___	___
	Have you ever had a head injury or concussion?	___	___	___
	Have you ever been knocked out, become unconscious, or lost your memory?	___	___	___
	Have you ever had a seizure?	___	___	___
	Do you have frequent or severe headaches?	___	___	___
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	___	___
	Have you ever had a stinger, burner, or pinched nerve?	___	___	___
18.	Last tetanus shot?	Date ___		
19.	Last eye exam?	Date ___		
20.	Last Menstrual period (if women)	Date ___		

Personal Habits

		Yes	No
1.	Smoking/smokeless tobacco	___	___
2.	Alcohol/non-medical drugs: marijuana, cocaine, etc.	___	___
3.	Steroids	___	___
4.	Eating Disorders – weight loss or gain?	___	___

Review of systems (Please check if you have any problems with any of the following areas of your body)

___	Skin	___	Lungs	___	Shoulders, Arms, Hands
___	Head	___	Heart	___	Hips, Legs, Feet
___	Eyes	___	Abdomen	___	Muscle–Strength, Feeling
___	Nose	___	Back	___	Mental, Emotional
___	Mouth/Throat	___	Urination, Bowel Control	___	Fatigue
___	Nutrition, Weight Control	___	Genital (including menstrual for women)	___	Other: What?
___	Neck	___		___	

I certify that the above information is correct to the best of my knowledge.

Student Signature____

Parent/Guardian Signature___________________________________

Both Student and Parent/Guardian Signatures Are Mandatory

Physical Examination

Height___________ Weight___________ Blood Pressure___________

Pulse: resting_____ 15 hops___________ after 2 minutes resting_______

Visual Acuity: Eyes (R) 20/___ w/o glasses_____ (L) 20/________ w/glasses_______

Other Testing	Normal	Abnormal Findings
1. General		
2. Skin		
3. HEENT		
4. Teeth (Dental Exam)		
5. Neck		
6. Lungs		
7. Heart (Sit and Stand)		
8. Abdomen		
9. Genitalia		
10. Musculoskeletal		
Neck		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Back		
Hip/Thigh		
Knee		
Shin/Calf		
Ankle/Leg		
Foot		
11. Peripheral Pulses		
12. Neurologic		
13. Mental Status		
14. Marfan Screen		

Other Tests (optional)

_________ Auditory _________ U/A _________ EKG

_________ % Body Fat _________ Drug Screen _________ Chest X-Ray

_________ Hgb/Hct _________ SMAC _________ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes______________ No______________ Limited___________

Additional Comments:

Examination Date___________ Physician's Signature______________________________

Physician's Assistant Signature*______________________________

Advanced Nurse Practitioner's Signature*______________________________

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Student's Name____________________ **School Name**____________________

Consent Form to Self-Administer Asthma Medication

(not needed if current form is already on file with school)

Parent Consent

I, ______________________, do hereby give my son/daughter, ______________________, Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

______________________________ ______________

Parent's Signature Date

Physician Consent

As a patient under my care, ______________________, is prescribed to self-administer the following asthma medication.

Medication______________________________

Purpose______________________________

Dosage______________________________

Time/Special Circumstances______________________________

____

______________________________ ______________

Physician's Signature Date