

# MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. **A physical examination conducted before May 1<sup>st</sup> is not valid for participation for the following school year.** All information is to remain confidential.

**HISTORY – To be completed by the student and parent(s).**

## QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

|                      |                               |                                 |             |                     |
|----------------------|-------------------------------|---------------------------------|-------------|---------------------|
| Name _____           | Male <input type="checkbox"/> | Female <input type="checkbox"/> | Grade _____ | Date of Birth _____ |
| Home Address _____   | Phone Number _____            |                                 |             |                     |
| Parent's Name _____  | Family Physician _____        |                                 |             |                     |
| Current School _____ | Date _____                    |                                 |             |                     |

**Explain "Yes" answers below. Circle questions to which you don't know the answer.**

Yes No

1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No
  2. Do you have an ongoing medical condition (like diabetes or asthma)?  Yes  No
  3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  Yes  No
  4. Are you taking medicine for ADHD?  Yes  No
  5. Do you have allergies to medicines, pollens, foods, or stinging insects?  Yes  No
  6. Have you ever passed out or nearly passed out DURING exercise?  Yes  No
  7. Have you ever passed out or nearly passed out AFTER exercise?  Yes  No
  8. Have you ever had discomfort, pain, or pressure in your chest during exercise?  Yes  No
  9. Does your heart race or skip beats during exercise?  Yes  No
  10. Has a doctor ever told you that you have (circle all that apply):  
 High blood pressure      A heart murmur  
 High cholesterol          A heart infection
  11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)  Yes  No
  12. Has anyone in your family died for no apparent reason?  Yes  No
  13. Does anyone in your family have a heart problem?  Yes  No
  14. Has any family member or relative died of heart problems or of sudden death before age 50?  Yes  No
  15. Does anyone in your family have Marfan syndrome?  Yes  No
  16. Have you ever spent the night in a hospital?  Yes  No
  17. Have you ever had surgery?  Yes  No
  18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below:  Yes  No
  19. Have you had any broken or fractured bones, or dislocated joints?  Yes  No  
If yes, circle below:
  20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?  Yes  No  
If yes, circle below:
- |            |            |          |           |       |           |                |             |
|------------|------------|----------|-----------|-------|-----------|----------------|-------------|
| Head       | Neck       | Shoulder | Upper arm | Elbow | Forearm   | Hand / fingers | Chest       |
| Upper back | Lower back | Hip      | Thigh     | Knee  | Calf/shin | Ankle          | Foot / toes |
21. Have you ever had a stress fracture?  Yes  No
  22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  Yes  No
  23. Do you regularly use a brace or assistive device?  Yes  No
  24. Has a doctor ever told you that you have asthma or allergies?  Yes  No

- |  |  |                          |                          |
|--|--|--------------------------|--------------------------|
| 25. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           |  | Yes                      | No                       |
| 26. Is there anyone in your family who has asthma?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever used an inhaler or taken asthma medicine?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you had infectious mononucleosis (mono) within the last month?                                    |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have any rashes, pressure sores, or other skin problems?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you had a herpes skin infection?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever had a head injury or concussion?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you been hit in the head and been confused or lost your memory?                                   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had a seizure?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have headaches with exercise?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Have you ever been unable to move your arms or legs after being hit or falling?                        |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. When exercising in the heat, do you have severe muscle cramps or become ill?                           |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Have you had any problems with your eyes or vision?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear glasses or contact lenses?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you wear protective eyewear, such as goggles or a face shield?                                      |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you happy with your weight?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Are you trying to gain or lose weight?   |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Have anyone recommended you change your weight or eating habits?                                       |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you limit or carefully control what you eat?  |  | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Do you have any concerns that you would like to discuss with a doctor?                                 |  | <input type="checkbox"/> | <input type="checkbox"/> |

### COVID-19 ADDENDUM

48. Have you ever been diagnosed with or suspected you had COVID-19?  Yes  No  
If yes, did you have 4 or more days of fever (greater than 100.4°F), and/or 1 or more week of myalgia, chills, or lethargy?  Yes  No
49. Have you ever been hospitalized due to COVID-19 or diagnosed with MIS-C?  Yes  No

### FEMALES ONLY

50. Have you ever had a menstrual period?  Yes  No
51. How old were you when you had your first menstrual period? \_\_\_\_\_
52. How many periods have you had in the last year? \_\_\_\_\_

**Explain "Yes" answers here:**

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**Allergies:** \_\_\_\_\_

**Required for School\* and Recommended Immunizations:** (please check if student is up-to-date):  Hepatitis A;  Hepatitis B;  Human Papillomavirus (HPV);

Influenza;  Measles, Mumps, Rubella (MMR)\*;  Meningococcal;  Polio\*;  Tetanus/Diphtheria/Pertussis (Tdap)\*;  Varicella (Chickenpox)\*

Date of last known tetanus shot (Tdap): \_\_\_\_\_

**PROVIDER'S PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP: Left Arm \_\_\_\_\_ / \_\_\_\_\_ Right Arm \_\_\_\_\_ / \_\_\_\_\_  
 Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

|                        | NORMAL | ABNORMAL FINDINGS | INITIALS |
|------------------------|--------|-------------------|----------|
| <b>MEDICAL</b>         |        |                   |          |
| Appearance             |        |                   |          |
| Eyes/ears/nose/throat  |        |                   |          |
| Hearing                |        |                   |          |
| Lymph nodes            |        |                   |          |
| Heart                  |        |                   |          |
| Murmurs                |        |                   |          |
| Pulses                 |        |                   |          |
| Lungs                  |        |                   |          |
| Abdomen                |        |                   |          |
| Hernia                 |        |                   |          |
| Skin                   |        |                   |          |
| <b>MUSCULOSKELETAL</b> |        |                   |          |
| Neck                   |        |                   |          |
| Back                   |        |                   |          |
| Shoulder/arm           |        |                   |          |
| Elbow/forearm          |        |                   |          |
| Wrist/hands/fingers    |        |                   |          |
| Hip/thigh              |        |                   |          |
| Knee                   |        |                   |          |
| Leg/ankle              |        |                   |          |
| Foot/toes              |        |                   |          |

\*Multiple examiner set-up only.

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CLEARANCE**

Typed or printed name of Student \_\_\_\_\_ Signature of Student \_\_\_\_\_

Cleared without restriction  
 Cleared with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared for  All sports  Certain sports \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician/medical provider [print or type] \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician/medical provider \_\_\_\_\_

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

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian \_\_\_\_\_ Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_ Address \_\_\_\_\_ Insurance (Company name) \_\_\_\_\_

Parent's Home Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_ Parent's Cell Phone \_\_\_\_\_ Additional Phone (if any-specify) \_\_\_\_\_

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL**