



HEALTH EXAMINATION *and* CONSENT FORM

It is required that 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: _____ Graduation Year: _____

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 after exercise?? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you use special equipment (pads, braces, neck rolls, mouth guard or eye guards, etc)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | |
| Have you been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever had problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | |
| Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any other medical problems (infectious mononucleosis, diabetes, ect.)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | |
| 5. Do you have any skin problems (itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | |
| 12. Have you ever 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 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 by school authorities for any illness or injury resulting from his/her athletic participation. I also consent to the release of any information contained in this form to carry out treatment and healthcare operations for the above named student.

If the health care provider's exam will be performed without compensation as part of the school's health examination program for participation in high school activities, I agree to the waiver provisions as set forth in Idaho Code Section 39-7703 and agree that the health care provider shall be immune from liability as specified in said section.

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 regulations 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 Pupils: Equal _____ Unequal _____.	
Normal	Abnormal Findings		
MEDICAL			
Pulses			
Heart			
Lungs			
Skin			
Ears, Nose, Throat			
Abdomen			
Genitalia (males)			
MUSCULOSKELETAL			
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
- 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)