



PRE-PARTICIPATION EXAMINATION FORM

Instructions for completing pre-participation (athletic)
Health Examination and Consent Form

COMPLETING THIS FORM:

- 1. PLEASE TYPE OR PRINT LEGIBLY
- 2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
- 3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
- 4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

- 1. School personnel should review form to assure it is completed properly.
- 2. ORIGINAL copy is to be retained in school files.

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

Name of	Student School	
Is the s	tudent covered by health/accident insurance? Yes No	
-	CONSENT FORM It or Guardian Statement of Permission, Approval, and Acknowledgement: gning below, I the parent or legal guardian of the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions. Purther consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death. Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days. Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf Tor Guardian Name Parent or Guardian Signature Parent or Guardian Signature Parent or Guardian Signature On Statement of the High School Activities Association. My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.	
If no in	surance provider, explain	
	CONSENT FORM	
•	Hereby consent to the above named student participating in the interscholastic athletic program at the	
•		
•	potential injuries may be severe in nature including such conditions as: fractures, brain injuries,	
•	if my student's health changes and would alter this evaluation, I will notify the school as soon as	
•	signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the	
Parent o	Parent or Guardian Signature	
Date		
Studer		
•	part and is made with the understanding that I have not violated any of the eligibility rules and	
•	Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and	

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

Date

parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

ame			Date of birth		
			Sport(s)		
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter me	edicines and supplements (herbal and nutritional) that you are currently	taking	
		10. 0			
Do you have any allergies? ☐ Yes ☐ No If yes, please ider ☐ Medicines ☐ Pollens		_,	ergy below. □ Food □ Stinging Insects		
xplain "Yes" answers below. Circle questions you don't know the an	swers t	0.	P-1100-110-110-1-1-1-1-1-1-1-1-1-1-1-1-1	,	
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	N
 Has a doctor ever denied or restricted your participation in sports for any reason? 			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		_
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			28. Is there anyone in your family who has asthma?		
Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Have you ever had surgery?			30 Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Flave you ever had a head Injury or concussion?		_
7. Does your heart ever race or sklp beats (irregular beats) during exercise?			35, Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?		
check all that apply: High blood pressure			37. Do you have headaches with exercise?		
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, fingling, or weakness in your arms or legs after being hit or falling?		
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or folling?		
Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		
during exercise?			41. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			43. Have you had any problems with your eyes or vision?		_
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		No	44. Have you had any eye injuries? 45. Do you wear glasses or contact lenses?		-
13. Has any family member or relative died of heart problems or had an	-		46. Do you wear protective eyewear, such as goggles or a face shield?		-
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		3	47. Do you worry about your weight?		-
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long 01	2	-	48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of londs?	W-022	-
			50. Have you ever had an eating disorder?		I
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	1		51. Do you have any concerns that you would like to discuss with a doctor?		T
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
selzures, or near drowning?			52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months? Explain "yes" answers here	l	
18. Have you ever had any broken or fractured bones or dislocated joints?			CAPIGHT YOU WHO IS HOLD		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
20. Have you ever had a stress fracture?					-
 Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) 					1100
22. Do you regularly use a brace, orthotics, or other assistive device?					
23. Do you have a bone, muscle, or joint injury that bothers you?					***
24. Do any of your joints become painful, swollen, feel warm, or look red?			PACE DESCRIPTION AND ADDRESS OF THE		_
25. Do you have any history of juvenile arthritis or connective tissue disease?				-	_
hereby state that, to the best of my knowledge, my answers to	Abo ob		ntions are complete and correct		

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM Date of birth Name PHYSICIAN REMINDERS 1. Consider additional questions on more sensitive issues . Do you feel stressed out or under a lot of pressure? . Do you ever feel sad, hopeless, depressed, or anxious? . Do you feel safe at your home or residence? . Have you ever tried cigarettes, chewing tobacco, snuff, or dip? . During the past 30 days, did you use chewing tobacco, snuff, or dip? . Do you drink alcohol or use any other drugs? · Have you ever taken anabolic steroids or used any other performance supplement? • Have you ever taken any supplements to help you gain or lose weight or improve your performance? Do you wear a seat belt, use a helmet, and use condoms? 2. Consider reviewing questions on cardiovascular symptoms (questions 5-14). **EXAMINATION** Welght ☐ Male ☐ Female Height BP Pulse Vision R 20/ L 20/ Corrected Y N NORMAL **ABNORMAL FINDINGS** MEDICAL Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) Eycs/ears/nose/throat Pupils equal Hearing Lymph nodes Heart* Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) Pulses · Simultaneous femoral and radial pulses Lungs Abdomen Genitourinary (males only) · HSV, lesions suggestive of MRSA, tinea corporis Neurologic ^c MUSCULOSKELETAL Neck Back Shoulder/arm Elbow/forearm Wrist/hand/fingers Hip/thigh Knee Leg/ankle Foot/toes Functional · Duck-walk, single leg hop *Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. *Consider GU exam if in private setting. Having third party present is recommended, *Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. ☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or Ireatment for ____ □ Not cleared □ Pending further evaluation □ For any sports ☐ For certain sports ____ Recommendations I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and

participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) Phone Address

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