MSHSL SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM

Minnesota State High School League

Student Name: _____ Birth Date: _____ Age: ____ Gender: M / F
Address: _____
Home Telephone: _____ - _____ - _____
School: _____ Grade: ____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check One Box)

☐ **(1) Participate in all school interscholastic activities without restrictions.**

☐ **(2) Participate in any activity not crossed out below.**

Sport classification based on contact

Collision Contact Sports		Limited Contact Sports		Non-contact Sports	
Basketball	Boys' Lacrosse	Baseball	Cheerleading	Badminton	Dance Team
Diving	Football	Field Events	Adapted Floor Hockey	Field Events	Golf
Ice Hockey	Soccer	High Jump	Nordic Skiing	Discus	Cross Country Running
Wrestling	Adapted Soccer	Pole Vault	Alpine Skiing	Shot Put	Swimming
		Gymnastics	Girls' Lacrosse	Tennis	Track
		Softball	Volleyball	Adapted Bowling	
		Adapted Softball			

Sport classification based on intensity and strenuousness

High Intensity High-to-Moderate Dynamic High-to-Moderate Static	High Intensity High-to-Moderate Dynamic Low Static	High Intensity Low Dynamic High-to-Moderate Static	Low Intensity Low Dynamic Low Static
Alpine Skiing	Badminton	Cheerleading	Golf
Cross Country Running	Baseball	Diving	
Distance Track Events	Dance Team	Field Events	
Football	Lacrosse (Boys and Girls)	Gymnastics	
Ice Hockey	Soccer		
Nordic Skiing	Softball		
Sprint Track Events	Swimming		
Wrestling	Tennis		
	Volleyball		

☐ **(3) Requires further evaluation before a final recommendation can be made.**
Additional recommendations for the school or parents**:** _____
_____

☐ **(4) Not cleared for:** ☐ **All Sports** ☐ **Specific Sports** _____
Reason: _____

I have examined the above named student and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. 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.

Attending Physician Signature: _____ Date of Exam: _____
Print Physician Name: _____
Address: _____
_____
Office Telephone: _____ - _____ - _____

COPY THIS CLEARANCE FORM FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE 3-PAGE FORM IN THE STUDENT'S MEDICAL RECORD.

Valid for 3 years from above date with a normal Annual Health Questionnaire. ☐ [Year 2 Normal] ☐ [Year 3 Normal]

IMMUNIZATIONS [Consider tD (age 12) ; MMR (2 required); hep B (3 required); varicella (or history of disease); poliomyelitis; influenza]
☐ Up-to-date (see attached school documentation) ☐ Not up-to-date **/** Specify _____
IMMUNIZATIONS GIVEN TODAY: _____

EMERGENCY INFORMATION
Allergies _____
Other Information _____
Emergency Contact: _____ Relationship _____
Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____
Personal Physician _____ Office Telephone _____ - _____ - _____

Reference: Preparticipation Physical Evaluation (Third Edition): AAFP, AAP, AMSSM, AOSSM, AOASM ; McGraw-Hill, 2005.

MSHSL SPORTS QUALIFYING PHYSICAL HISTORY FORM

DATE OF EXAM _____

Student Name: _____ Birth Date: _____ Age: ____ Gender: M / F

Address: _____

Home Telephone: _____ - _____ - _____

School: _____ Grade: ____ Sports: _____

History

Circle Y for Yes or N for No Circle Question Number (1. etc) of questions for which the answer is unknown.

1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? ..... Y / N
2. Do you have an ongoing medical condition (like diabetes or asthma)? ..... Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ..... Y / N
   List: _____
4. Do you have allergies to medicines, pollens, foods, or stinging insects? ..... Y / N
5. Have you ever passed out or nearly passed out DURING exercise? ..... Y / N
6. Have you ever passed out or nearly passed out AFTER exercise? ..... Y / N
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ..... Y / N
8. Does your heart race or skip beats during exercise? ..... Y / N
9. Has a doctor ever told you that you have? (circle): High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram, stress test) ..... Y / N
11. Has anyone in your family died suddenly and unexpectedly for no apparent reason? ..... Y / N
12. Does anyone in your family have a heart problem? ..... Y / N
13. Has any family member or relative died of heart problems or of sudden death before age 50? ..... Y / N
14. Has anyone in your family less than 50 years old had unexplained drowning while swimming or an unexplained car accident? ..... Y / N
15. Does anyone in your family have Marfan syndrome? ..... Y / N
16. Have you ever spent the night in a hospital? ..... Y / N
17. Have you ever had surgery? ..... Y / N
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? ..... Y / N
19. Have you had any broken or fractured bones, or dislocated joints? ..... Y / N
20. Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? . Y / N
    If Yes in Questions 18, 19 or 20, please circle the area below:
    Head Neck Shoulder Chest Upper Arm Elbow Forearm Hand/Fingers Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes
21. Have you ever had a stress fracture? ..... Y / N
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ..... Y / N
23. Do you regularly use a brace or assistive device? ..... Y / N
24. Has a doctor ever told you that you have asthma or allergies? ..... Y / N
25. Do you cough, wheeze, chest tightness, or have difficulty breathing during or after exercise? ..... Y / N
26. Is there anyone in your family who has asthma? ..... Y / N
27. Have you ever used an inhaler or taken asthma medicine? ..... Y / N
28. Do you develop a rash or hives when you exercise? ..... Y / N
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ..... Y / N
30. Have you had infectious mononucleosis (mono) within the last month? ..... Y / N
31. Do you have any rashes, pressure sores, or other skin problems? ..... Y / N
32. Have you had a herpes skin infection? ..... Y / N
33. Have you ever had a head injury or concussion? ..... Y / N
34. Have you been hit in the head and been confused or lost your memory? ..... Y / N
35. Have you ever had a seizure? ..... Y / N
36. Do you have headaches with exercise? ..... Y / N
37. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ..... Y / N
38. Have you ever been unable to move your arms or legs after being hit or falling? ..... Y / N
39. When exercising in the heat, do you have severe muscle cramps or become ill? ..... Y / N
40. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ..... Y / N
41. Have you had any problems with your eyes or vision? ..... Y / N
42. Do you wear glasses or contact lenses? ..... Y / N
43. Do you wear protective eyewear, such as goggles or a face shield? ..... Y / N
44. Are you happy with your weight? ..... Y / N
45. Are you trying to gain or lose weight? ..... Y / N
46. Has anyone recommended you change your weight or eating habits? ..... Y / N
47. Do you limit or carefully control what you eat? ..... Y / N
48. Do you get tired more quickly than your friends do during exercise? ..... Y / N
49. Do you have any concerns that you would like to discuss with a doctor? ..... Y / N

FEMALES ONLY

50. Have you ever had a menstrual period? ..... Y / N
51. How old were you when you had your first menstrual period? _____
52. How many menstrual periods have you had in the last year? _____

Notes: _____

_____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

_____ _____ _____

Parent or Legal Guardian Signature Student-Athlete Signature Date

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Student Name: _____ Birth Date: _____ Age: ____ Gender: M / F

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:

_____
_____
_____

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____
Pulse_____ BP _____ / _____ (_____/_____)
Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Hearing: R____ L____ (Audiogram or confrontation)

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
HEENT	Y / N		
Eyes	Y / N		
Fundoscopic	Y / N		
Pupils	Equal / Unequal		
Ears/Nose	Y / N		
Hearing	Y / N		
Throat	Y / N		
Dental	Y / N		
Lymph Nodes	Y / N		
Thyroid	Y / N		
Heart	Y / N		
Murmurs	Y / N		
Pulses	Y / N		
Lungs	Y / N		
Abdomen	Y / N		
Genitourinary (Male)	Y / N		
Hernia	Y / N		
Tanner Staging (optional)	I II III IV V		
Skin	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/Fingers	Y / N		
Hip/Thigh	Y / N		
Knee	Y / N		
Leg/Ankle	Y / N		
Foot/Toes	Y / N		
Duck Walk	Y / N		

*** Required Only if Multiple Examiners**

Notes:

_____
_____
_____

Assessment:

Immunizations: Up-to-Date

Health maintenance:

Plan:

Immunize if needed (Required by age 12: DTaP series plus tD with Pertusis, 4 HIB, 2MMR, 3 HBV, 4 IPV)
Consider Flu Shot (Asthma, winter athletes)
Lifestyle, health, and safety counseling
Discussed dental care and mouthguard use
Discussed Lead and TB exposure – (Testing indicated / not indicated)