IMPORTANT INFORMATION FOR PARENT / GUARDIAN / ATHLETE: Page 1 is the ONLY copy we require on file. If your student participates in PI Adapted Sports, please also include pgs. 4 & 5. PLEASE DO NOT SEND PAGES 2-3 or any updated immunizations to the Activities Office. (Please read below regarding updating immunizations*). Physicians please fax Page 1 to: (952) 401-5905. Families, please email, fax or drop off Page 1 to your school Activities Office staff. Include pgs. 4 & 5 only if it applies to the student.

2019-2020 SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM

Minnesota State High School League

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

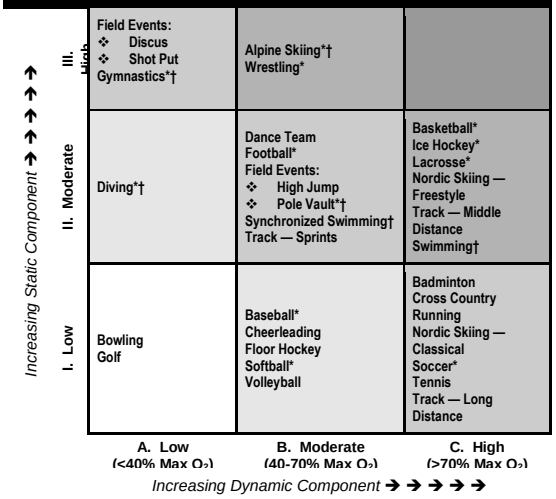
I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check Only One Box)

☐ **(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	Baseball	Badminton
Cheerleading	Field Events:	Bowling
Diving	❖ High Jump	Cross Country Running
Football	❖ Pole Vault	Dance Team
Gymnastics	Floor Hockey	Field Events:
Ice Hockey	Nordic Skiing	❖ Discus
Lacrosse	Softball	❖ Shot Put
Alpine Skiing	Volleyball	Golf
Soccer		Swimming
Wrestling		Tennis
		Track

Sport Classification Based on Intensity & Strenuousness



Please Note that MHS also requires sports physicals on file for: Cheerleading, Marching Band and Fall Performance Dance Teams.

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

_____
_____

☐ **(4) Not medically eligible for:**
☐ **All Sports** ☐ **Specific Sports**
Specify : _____
_____

Sport Classification Based on Intensity & Strenuousness: This classification is based on peak static and dynamic components achieved during competition. It should be noted, however, that higher values may be reached during training. The increasing dynamic component is defined in terms of the estimated percent of maximal oxygen uptake ($MaxO_2$) achieved and results in an increasing cardiac output. The increasing static component is related to the estimated percent of maximal voluntary contraction (MVC) reached and results in an increasing blood pressure load. The lowest total cardiovascular demands (cardiac output and blood pressure) are shown in lightest shading and the highest in darkest shading. The graduated shading in between depicts low moderate, moderate, and high moderate total cardiovascular demands. *Danger of bodily collision. †Increased risk if syncope occurs. Reprinted with permission from: Maron BJ, Zipes DP. 36th Bethesda Conference: eligibility recommendations for competitive athletes with cardiovascular abnormalities. *J Am Coll Cardiol.* 2005; 45(8):1317–1375.

I have examined the above-named student and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. The student does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form. 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 or guardians).

Attending Physician Signature_____ Date of Exam:_____
Print Physician Name: _____ Clinic Stamp: _____
Office/Clinic Name_____ Clinic Address: _____
Telephone: ____ - ____ - _____ FAX: ____-____-_____ E-Mail:: _____

***IMMUNIZATIONS - PHYSICIANS PLEASE NOTE: IF IMMUNIZATIONS ARE GIVEN TODAY, PLEASE GIVE THE PATIENT A SEPARATE IMMUNIZATION PAGE FOR THE PARENT/GUARDIAN TO SHARE WITH THEIR SCHOOL HEALTH OFFICE.**

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

This form is valid for 3 calendar years from date of the exam, unless otherwise noted by the physician with additional student eligibility and normal Annual health questionnaire forms completed each year.

Reference: Preparticipation Physical Evaluation (4th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2010.

2020-2021 SPORTS QUALIFYING PHYSICAL HISTORY FORM

Minnesota State High School League

Name: _____ Date of birth: _____
Date of examination: _____ Sport(s): _____
Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

Past and current medical conditions: _____
Have you ever had surgery? If yes, list all past surgeries. _____
Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).
_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(If the sum of responses to questions 1 & 2 or 3 & 4 are >or = 3, evaluate.)

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

GENERAL QUESTIONS

1.Do you have any concerns that you would like to discuss with your provider? ..... Y / N
2. Has a provider ever denied or restricted your participation in sports for any reason? ..... Y / N
3. Do you have any ongoing medical issues or recent illness? ..... Y / N

HEART HEALTH QUESTIONS ABOUT YOU[a]

4. Have you ever passed out or nearly passed out during or after exercise? ..... Y / N
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ..... Y / N
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? ..... Y / N
7. Has a doctor ever told you that you have any heart problems? ..... Y / N
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. ..... Y / N
9. Do you get light-headed or feel shorter of breath than your friends during exercise? ..... Y / N
10. Have you ever had a seizure? ..... Y / N

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY[a]

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? ..... Y / N
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? ..... Y / N
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? ..... Y / N

BONE AND JOINT QUESTIONS

14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? ..... Y / N
15. Do you have a bone, muscle, ligament, or joint injury that bothers you? ..... Y / N

MEDICAL QUESTIONS

16. Do you cough, wheeze, or have difficulty breathing during or after exercise? ..... Y / N
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? ..... Y / N
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? ..... Y / N
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? ..... Y / N
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? ..... Y / N
22. Have you ever become ill while exercising in the heat? ..... Y / N
23. Do you or does someone in your family have sickle cell trait or disease? ..... Y / N
24. Have you ever had or do you have any problems with your eyes or vision? ..... Y / N
25. Do you worry about your weight? ..... Y / N
26. Are you trying to or has anyone recommended that you gain or lose weight? ..... Y / N
27. Are you on a special diet or do you avoid certain types of foods or food groups? ..... Y / N
28. Have you ever had an eating disorder? ..... Y / N

FEMALES ONLY

29. Have you ever had a menstrual period? ..... Y / N
30. How old were you when you had your first menstrual period? _____
31. When was your most recent menstrual period? _____
32. How many periods have you had in the past 12 months? _____

Notes: _____
_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

_____ _____ _____
Student-Athlete Signature Parent or Legal Guardian Signature Date

2020-2021 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Minnesota State High School League

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 been hit, kicked, slapped, punched, sexually abused, inappropriately touched, or threatened with harm by anyone close to you?
5. Have you ever tried cigarette, cigar, pipe, e-cigarette smoking, or vaping, even 1 or 2 puffs? Do you currently smoke?
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?
7. During the past 30 days, have you had any alcohol drinks, even just one?
8. Have you ever taken steroid pills or shots without a doctor's prescription?
9. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
10. 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			
Circle any Marfan stigmata present		Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
HEENT			
Eyes			
Fundoscopic			
Pupils			
Hearing			
Cardiovascular*			
Describe any murmurs present (standing, supine, +/- Valsalva)			
Pulses (simultaneous femoral & radial)			
Lungs			
Abdomen			
Tanner Staging (optional)		Circle: I II III IV V	
Skin (No HSV, MRSA, Tinea corporis)			
Musculoskeletal			
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand / Fingers			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot / Toes			
Functional (Double-leg squat test, single leg squat test, box drop or step drop box test)			

*** Consider ECG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings**

** **Required Only if Multiple Examiners**

Additional Notes: _____
_____
_____

IMMUNIZATIONS: ☐ Up-to-Date ☐ **Immunizations given today:** _____

☐ **NOT** Up-to-Date. Specify: Tdap;, meningococcal (MCV4, 2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses or history of the disease); polio (3-4 doses); influenza (annual)

HEALTH MAINTENANCE:

☐ Lifestyle, health, immunization and safety counseling ☐ Discussed dental care and mouthguard use
☐ Discussed Lead and TB exposure – (Testing indicated / not indicated) ☐ Eye Refraction if indicated

Attending Physician Signature:_____ Date: _____

Minnesota State High School League
ATHLETE WITH DISABILITIES SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

1. Type of disability:_____
2. Date of disability: _____
3. Classification (if available): _____
4. Cause of disability (birth, disease, injury, or other): _____
5. List the sports you are playing: _____

_____

6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? Y / N
7. Do you use any special brace or assistive device for sports? Y / N
8. Do you have any rashes, pressure sores, or other skin problems? Y / N
9. Do you have a hearing loss? Do you use a hearing aid? Y / N
10. Do you have a visual impairment? Y / N
11. Do you use any special devices for bowel or bladder function? Y / N
12. Do you have burning or discomfort when urinating? Y / N
13. Have you had autonomic dysreflexia? Y / N
14. Have you ever been diagnosed as having a heat-related or cold-related illness? Y / N
15. Do you have muscle spasticity? Y / N
16. Do you have frequent seizures that cannot be controlled by medication? Y / N

Explain "Yes" answers here:

_____
_____
_____

Please indicate whether you have ever had any of the following conditions:
Atlantoaxial instability Y / N
Radiographic (x-ray) evaluation for atlantoaxial instability Y / N
Dislocated joints (more than one) Y / N
Easy bleeding Y / N
Enlarged spleen Y / N
Hepatitis Y / N
Osteopenia or osteoporosis Y / N
Difficulty controlling bowel Y / N
Difficulty controlling bladder Y / N
Numbness or tingling in arms or hands Y / N
Numbness or tingling in legs or feet Y / N
Weakness in arms or hands Y / N
Weakness in legs or feet Y / N
Recent change in coordination Y / N
Recent change in ability to walk Y / N
Spina bifida Y / N
Latex allergy Y / N

Explain "Yes" answers here:

_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

_____ _____ Date: _____

Signature of athlete: Signature of parent or guardian

Adapted from 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Minnesota State High School League
2020-2021 PI ADAPTED ATHLETICS MEDICAL ELIGIBILITY FORM Addendum
(Use only for Adapted Athletics - PI Division)

The MSHSL has competitive interscholastic Physically Impaired (PI) competition. Students who are deemed fit to participate in competitive athletics from a MSHSL sports qualifying exam should meet the criteria below to participate in Adapted Athletics – PI Division.

The MSHSL Adapted Athletics PI Division program is specifically intended for students with physical impairments who are medically eligible to compete in competitive athletics. A student is administratively eligible to compete in the PI Division with one of the two following criteria:

The student must have a diagnosed and documented impairment specified from one of the two sections below:
(Must be diagnosed and documented by a Physician, Physician's Assistant, and/or Advanced Practice Nurse.)

1. _____ Neuromuscular _____Postural/Skeletal _____Traumatic

_____Growth _____Neurological Impairment

Which: _____affects Motor Function _____modifies Gait Patterns

(Optional) _____Requires the use of prosthesis or mobility device, including but not limited to canes, crutches, walker or wheelchair.

2. _____ Cardio/Respiratory Impairment that is deemed safe for competitive athletics, but limits the intensity and duration of physical exertion such that sustained activity for over five minutes at 60% of maximum heart rate for age results in physical distress in spite of appropriate management of the health condition.

(NOTE:) A condition that can be appropriately managed with appropriate medications that eliminate physical or health endurance limitations WILL NOT be considered eligible for adapted athletics.

Specific exclusions to PI competition:

The following health conditions, without coexisting physical impairments as outlined above, do not qualify the student to participate in the PI Division even though some of the conditions below may be considered Health Impairments by an individual's physician, a student's school, or government agency. This list is not all-inclusive and the conditions are examples of non-qualifying health conditions; other health conditions that are not listed below may also be non-qualifying for participation in the PI Division.

Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Emotional Behavioral Disorder (EBD), Autism spectrum disorders (including Asperger's Syndrome), Tourette's Syndrome, Neurofibromatosis, Asthma, Reactive Airway Disease (RAD), Bronchopulmonary Dysplasia (BPD), Blindness, Deafness, Obesity, Depression, Generalized Anxiety Disorder, Seizure Disorder, or other similar disorders.

Student Name_____

Provider
(PRINT)_____

Provider
(SIGNATURE)_____

Date of Exam _____