



Pre-participation Examination



To be completed by athlete or parent prior to examination.

Name: Last, First, Middle, School Year, Address, City/State, Phone No., Birthdate, Age, Class, Student ID No., Parent's Name, Phone No., Address, City/State

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No if yes, please identify specific allergy below. Medicines Pollens Food Stinging Insects

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

Answer All Questions Responde Todas Las Preguntas

GENERAL QUESTIONS table with 25 rows and 3 columns (Question, Yes, No)

MEDICAL QUESTIONS table with 25 rows and 3 columns (Question, Yes, No) and FEMALES ONLY section

Explain "yes" answers here

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

Signature of athlete, Signature of parent/guardian, Date



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PHYSICAL EXAMINATION FORM

Name Last First Middle

EXAMINATION table with columns for Height, Weight, BP, Pulse, Vision, L 20/, Corrected, and rows for MEDICAL (Appearance, Eyes/ears/nose/throat, Lymph nodes, Heart, Pulses, Lungs, Abdomen, Genitourinary, Skin, Neurologic) and MUSCULOSKELETAL (Neck, Back, Shoulder/arm, Elbow/forearm, Wrist/hand/fingers, Hip/thigh, Knee, Leg/Ankle, Foot/toes, Functional).

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.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date. Yes No Limited Examination Date

Additional Comments:

Physician's Signature Physician's Name

Physician's Assistant Signature* PA's Name

Advanced Nurse Practitioner's Signature* ANP's Name

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

IHSA Steroid Testing Policy Consent to Random Testing (This section for high school students only) 2013-2014 school term

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

Signature of student-athlete Date Signature of parent-guardian Date