LOGAN HEALTH

# MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. While **Logan Health is the preferred medical provider of the MHSA, parents/guardians may choose their own medial provider for their Physical Examination** This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

**HISTORY – To be completed by the student and parent(s).**

**QUESTIONNAIRE FOR ATHLETIC PARTICIPATION** (PLEASE PRINT)

Name _____ Male ☐ Female ☐ Grade _____ Date of Birth _____

Home Address _____ Phone Number _____

Parent's Name _____ Family Physician _____

Current School _____ Date _____

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

| | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | ☐ | ☐ |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | ☐ | ☐ |
| 4. Are you taking medicine for ADHD? | ☐ | ☐ |
| 5. Do you have allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 6. Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 7. Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| 9. Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 10. Has a doctor ever told you that you have (circle all that apply): High blood pressure, A heart murmur, High cholesterol, A heart infection | | |
| 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | ☐ | ☐ |
| 12. Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 13. Does anyone in your family have a heart problem? | ☐ | ☐ |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| 15. Does anyone in your family have Marfan syndrome? | ☐ | ☐ |
| 16. Have you ever spent the night in a hospital? | ☐ | ☐ |
| 17. Have you ever had surgery? | ☐ | ☐ |
| 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: If yes, circle affected area below: | ☐ | ☐ |
| 19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: | ☐ | ☐ |
| 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | ☐ | ☐ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand / fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot / toes |

| | | |
|---|---|---|
| 21. Have you ever had a stress fracture? | ☐ | ☐ |
| 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 23. Do you regularly use a brace or assistive device? | ☐ | ☐ |
| 24. Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| 25. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 26. Is there anyone in your family who has asthma? | ☐ | ☐ |
| 27. Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 29. Have you had infectious mononucleosis (mono) within the last month? | ☐ | ☐ |
| 30. Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 31. Have you had a herpes skin infection? | ☐ | ☐ |
| 32. Have you ever had a head injury or concussion? | ☐ | ☐ |
| 33. Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 34. Have you ever had a seizure? | ☐ | ☐ |
| 35. Do you have headaches with exercise? | ☐ | ☐ |
| 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| 37. Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 38. When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 40. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 41. Do you wear glasses or contact lenses? | ☐ | ☐ |
| 42. Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| 43. Are you happy with your weight? | ☐ | ☐ |
| 44. Are you trying to gain or lose weight? | ☐ | ☐ |
| 45. Have anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 46. Do you limit or carefully control what you eat? | ☐ | ☐ |
| 47. Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

**FEMALES ONLY**

| | | |
|---|---|---|
| 48. Have you ever had a menstrual period? | ☐ | ☐ |
| 49. How old were you when you had your first menstrual period? | _____ | |
| 50. How many periods have you had in the last year? | _____ | |

**Explain "Yes" answers here:**

_____

_____

_____

**Allergies:** _____

**Required for School* and Recommended Immunizations:** (please check if student is up-to-date): ☐ Hepatitis A; ☐ Hepatitis B; ☐ Human Papillomavirus (HPV); ☐ Influenza; ☐ Measles, Mumps, Rubella (MMR)*; ☐ Meningococcal; ☐ Polio*; ☐ Tetanus/Diphtheria/Pertussis (Tdap)*; ☐ Varicella (Chickenpox)*

Date of last known tetanus shot (Tdap): _____

## PROVIDER'S PHYSICAL EXAMINATION FORM

**Name** _____ **Date of Birth** _____

**Height** _____ **Weight** _____ **Pulse** _____ **BP: Left Arm** _____/_____ **Right Arm** _____/_____

**Vision R 20/**_____ **L 20/**_____ **Corrected: Y N Pupils: Equal** _____ **Unequal** _____

| | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---|---|---|---|
| **MEDICAL** | | | |
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Hernia | | | |
| Skin | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hands/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

*Multiple examiner set-up only.

Notes: _____

_____

_____

## CLEARANCE

_____ _____

Typed or printed name of Student Signature of Student

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports _____ Reason: _____

Recommendations: _____

_____

_____

**Name of physician/medical provider** [print or type] _____ Date _____

Address _____ Phone _____

**Signature of physician/medical provider** _____

## PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

_____ _____

Typed or printed name of parent or guardian Signature of parent or guardian

_____ _____ _____

Date Address Insurance (Company name)

_____ _____ _____ _____

Parent's Home Phone Parent's Work Phone Parent's Cell Phone Additional Phone (if any-specify)

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL**

(Updated (4/23)