



### **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.

Pre-Participation Health Examination Form, Updated November11, 2019

## Participant & Parental Disclosure and Consent Document

A STORE

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 student covered by health/accident insurance?	Yes No
Name of health insurance provider	
If no insurance provider, explain	

#### CONSENT FORM

#### Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to 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.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports 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. <u>http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf</u>

Parent or Guardian Name

Parent or Guardian Signature

Date

#### Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- 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 parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student

Date

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL <u>PRIOR</u> TO PARTICIPATION.



#### ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest

#### **ATHLETE INFORMATION**

Athlete Name:	Date of Exam:				
Sport(s):					
Birth date:	Age:	Grade in school	Gender:	School year:	
Athlete Cell Phone No. (	)	Athlete Addr	ess:		

EXAMINATION: TO BE FILLED OUT BY PHYSICIAN ONLY						
Height: Weight: □ Male □ Female				Pulse: BP: % Body Fat (opt)		
Vision: Left/	Right	/ Correct	ed:	□ Yes □ No P	upils: 🗆	Equal 🗆 Unequal
Immunizations: Tetanu	IS	MMR		Hep B Chick	kenpox	
GENERAL MEDICAL (please initial)		1	MUSCULOSKELETAL (please initial)			
	Normal	Abnormal Findings			Normal	Abnormal Findings
Appearance (Marfan stigmata)				Neck		
Eyes/Ears/Nose/Throat (Pupils Equal, Hearing)				Back		
Lymph Nodes				Shoulder/ Arm		
Heart (murmurs)				Elbow/ Forearm		
Pulses (Simultaneous femoral and radial pulses)				Wrist/ Hand/ Fingers		
Lungs				Hip/ Thigh		
Abdomen				Knee		
Skin (HSV, MRSA, tinea corporis)				Leg/ Ankle		
Neurological				Foot/ Toes		
Genitourinary (males only)				Functional (Duck walk, single leg hop)		

ATHLETIC PARTICIPATION RECOMMENDATIONS (*Physician MUST select one item listed below*)

FULL & UNLIMITED PARTICIPATION     LIMITED PARTICIPATION—May NOT participate in the     CLEARED PENDING—Documented follow up of:     NOT CLEARED FOR ATHLETIC PARTICIPATION Phys	
Physician's Name: (Please print) Physician Signature: Date: IF THIS FORM IS NOT FULLY COMPLETED INCLUDING DOCTOR ADDRESS AND NUMBER, IT WILL NOT BE ACCEPTED	Physician's Office Address Telephone: ()



#### ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

Must be completed every school year by the athlete

and parent prior to any try-out, practice, or athletic contest

Athlete Name: \_

#### Date of Birth\_\_\_

#### **MEDICAL HISTORY**

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

Allergies: Do you have any	allergies? 🗆 Yes 🗆 No If yes, please identify sp	pecific allergy.	
Medicines	Pollens	□ Food	Stinging Insects
	ANY "YES" RESPONSES MUST BE	EXPLAINED IN FULL AFTER E	ACH QUESTION IN THE SPACE

Hiss account even denied or relational of matching by presented?       Image: Constraint of the second	Yes	No
Additional Chemical Diseases: Interdional Control  Additional Chemical Disease: Interdional Chemical D		
How you ever spent the night in the hospital?         Is the anyone in your family how has authma?           Have you ever had surger?         No         No         No           HAXEN TEALTH ULESTIONS ABOUT YOU         Yes         No         No         No           Have you ever had surger?         No         No         No         No         No           Have you ever had discontrol, pain, tightness, or pressure in your family have and intectors monoucleositic (mono) within the last marth?         No		
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all that Apply:		
Has a doctor ever ordered a test for your heart? (e.g. ECG/EKG, Echocardiogram?)       Have you had any problems with your eyes or vision?         Do you get light headed or feel more short of breath than expected during exercise?       Do you wear glasses or contact lenses?         Day you get note tired or short of breath more quickly than your friends during exercise?       Do you wear glasses or contact lenses?         Day you get note tired or short of breath more quickly than your friends during exercise?       Do you wear protective eye wear such as goggles, or a face shield?         HAS any family member or relative clied of a heart problem or had an unexpected or unexplained sudden death before age 50 (including) drowing, unexplained death before age 50 (including) drowing, unexplained cleath before age 50 (including) drowing, unexplained cleath before age 50 (including) drowing, unexplained during, unexplained subtromy gathly. Long 20 (including) drowing, unexplained subtromy gathly. Long 20 (including) drowing, unexplained subtromy gathly. Long 20 (including) drowing 20 (including) drowing a negative in your family have a heart problem, pacemaker, or implanted pelinitiator?       Are you on a special dlet or do you avoid certain types of foods?         Debenaryone in your family have a heart problem, pacemaker, or implanted pelinitiator?       Have you ever had an exing this exercising in the heat?         Have you ever had an injury that bone, muscle, ligament or tendon that caused you you get requent muscle camps when exercising?       Do you get requent muscle camps when exercising?         Have you ever had an injury that bone, muscle, ligament or tendon that caused?       Do you and trequent muscle camps when exerci		
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HEART HEALTH QUESTIONS ABOUT YOUR FAMILY       Yes       No       Do you worry about your weight?         Has any family member or relative died of a heart problem or had an unexpected or unexplained stude ndath before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?       Are you trying to or has anyone recommended that you gain or lose weight?         Does anyone in your family have hypertrophic cardiomyopathy. Long OT syndrome, Sho, Buyada syndrome or catecholaminergic polymorphic ventricular tachycardia?       Are you on a special diet or do you avoid certain types of foods?         Does anyone in your family have hypertrophic cardiomyopathy. Long OT near drowning?       Have you ever had an eating disorder?       Have you ever had an eating disorder?         BONE AND JOINT OUESTIONS       Yes       No       Hext ILLNESS QUESTIONS         Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?       Do you or someone in your family have sickle cell trait or disease?         Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or cutches?       Hext D AND NECK HEALTH QUESTIONS         Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, or ofthics, or other assistive devices?       Do you nave headaches with exercise?         Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, or ofthics, or other assistive devices?       Hexe you ever had a head injury or concussion?         Do you have a bone, muscle,		
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Do you have a bone, muscle, or joint injury that bothers you?       Have you ever had numbness, tingling, or weakness in your arms of legs after being hit or falling?         Do any of your joints become painful, swollen, feel warm or look red?       Have you ever been unable to move your arms or legs after being hit or falling?         Do you have any history of juvenile arthritis, or connective tissue disease?       FEMALES ONLY         Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? Specify below if yes       When was your first menstrual period (age when started)?         If yes, check the appropriate box and explain below:       When was your most recent menstrual period?         Head       Neck         Back       Shoulder         Arm       Elbow         Finger       What was the longest time between periods have you had in the last year?         What was the longest time between periods in the last year?		
Do any of your joints become painful, swollen, feel warm or look red?       Have you ever been unable to move your arms or legs after being hit or falling?         Do you have any history of juvenile arthritis, or connective tissue disease?       FEMALES ONLY         Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? Specify below if yes       When was your first menstrual period (age when started)?         If yes, check the appropriate box and explain below:       When was your most recent menstrual period?         Have       Neck         Back       Shoulder         Arm       Elbow         Finger       Wrist         Hand       Shin/Calf		
Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? Specify below if yes     When was your first menstrual period (age when started)?       If yes, check the appropriate box and explain below:     When was your most recent menstrual period?       Head     Neck       Back     Shoulder       Arm     Elbow       Finger     When was your most recent menstrual period?       How much time do you usually have from the start of one period to the start of an How many periods have you had in the last year?       What was the longest time between periods in the last year?		
dislocation in any joint? Specify below if yes       When was your most recent menstrual period?         If yes, check the appropriate box and explain below:       When was your most recent menstrual period?         Head       Neck         Back       Shoulder         Arm       Elbow         Finger       Wrist         Hand       Shin/Calf		
If yes, check the appropriate box and explain below:       When was your most recent menstrual period?         Head       Neck         Back       Shoulder         Arm       Elbow         Finger       Wrist         Hand       Shin/Calf		
Back       □ Shoulder         How much time do you usually have from the start of one period to the start of an end of the start of the start of an end of the start of		
Back     Constraints       Chrm     Clobal       Finger     Wrist       Hand     Shin/Calf	nother?	
□ Finger       □ Wrist         □ Hand       □ Shin/Calf         What was the longest time between periods in the last year?		
Hand D Shin/Calf What was the longest time between periods in the last year?		
Thigh What was the longest time between periods in the last year?		
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