

FORM A

North Dakota High School Activities Association **Date** _____
Athletic Pre-participation Health History Screening and Physical Examination

This form must be completed prior to participation in NDHSAA athletic events. A health history screening and physical examination is required **EVERY TWO YEARS**, unless the Health History Screening indicates need for more frequent examinations.

Health History Screening (Must be completed prior to the physical examination)

Name _____ Sex _____ Age _____ Date of birth _____

Address _____ Grade _____

Sport(s) you plan to participate in: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Explain "Yes" answers below: To be completed by student and parent/legal guardian

- | | | | |
|-----|---|---|---|
| 1. | Have you had a medical problem or injury since your last evaluation? | Y | N |
| 2. | Have you ever been hospitalized? | Y | N |
| 3. | Have you ever had surgery? | Y | N |
| 4. | Are you presently taking any medications or pills? (Include vitamins, prescriptions, non-prescriptions) | Y | N |
| 5. | Do you have any allergies (medicine, bees or other stinging insects)? | Y | N |
| 6. | Have you ever passed out during or after exercise? | Y | N |
| 7. | Have you ever been dizzy during or after exercise? | Y | N |
| 8. | Have you ever had chest pain during or after exercise? | Y | N |
| 9. | Do you tire more quickly than your friends during exercise? | Y | N |
| 10. | Have you ever had high blood pressure? | Y | N |
| 11. | Have you ever been told that you have a heart murmur? | Y | N |
| 12. | Have you ever had racing of your heart or skipped heartbeats? | Y | N |
| 13. | Have anyone in your family died of heart problems or a sudden death before age 50? | Y | N |
| 14. | Do you have any skin problems (itching, rashes, acne)? | Y | N |
| 15. | Have you ever had a head injury or suffer from headaches? | Y | N |
| 16. | Have you ever been knocked unconscious? | Y | N |
| 17. | Have you ever had a seizure? | Y | N |
| 18. | Have you ever had a stinger, burner or pinched nerve? | Y | N |
| 19. | Have you had heat or muscle cramps? | Y | N |
| 20. | Have you ever been dizzy or passed out in the heat? | Y | N |
| 21. | Do you have trouble breathing or do you cough during or after activity? | Y | N |
| 22. | Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? | Y | N |
| 23. | Have you had any problem with your eyes or vision? | Y | N |
| 24. | Do you wear glasses or contacts or protective eye wear? | Y | N |
| 25. | Have you had any other medical problems (infectious mononucleosis, diabetes, etc.) | Y | N |
| 26. | Are there concerns you wish to discuss? | Y | N |

Explain "Yes" answers: _____

27. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? (Please check appropriate ones)
- | | | | | | |
|-------------|-----------------|---------------|-----------------|-------------|-------------|
| Head _____ | Shoulder _____ | Thigh _____ | Neck _____ | Elbow _____ | Knee _____ |
| Chest _____ | Scoliosis _____ | Forearm _____ | Shin/calf _____ | Back _____ | Wrist _____ |
| Ankle _____ | Hip _____ | Hand _____ | Foot _____ | | |

28. When was your last tetanus shot? _____

29. When was your last measles immunization? _____

FEMALES ONLY

30. When was your first menstrual period? _____

31. When was your last menstrual period? _____

32. What was the longest between your periods last year? _____ Are they painful? Y N

Permission for Medical Treatment: In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association. I hereby state to the best of my knowledge my answers to the above questions are correct. I approve participation in athletic activities. I hereby authorize release of the information contained in this document to a School Nurse, Certified Athletic Trainer, A. D., Superintendent or Principal.

Date _____ Signature of Athlete _____

Signature of Parent/Guardian _____

Physical Examination (to be completed by a Doctor of Medicine or Osteopathy, Nurse Practitioner or Physician Assistant)

Vision R 20/____ L 20/____
 Anisocoria Y____ N____
 Ht____ Wt____ BP____ Body Fat %____ (optional)

General Appearance

Head Normal/Abnormal_____
 Eyes Normal/Abnormal_____
 Ears Normal/Abnormal_____
 Nose Normal/Abnormal_____
 Mouth Normal/Abnormal_____
 Dental Normal/Abnormal_____
 Thyroid Normal/Abnormal_____
 Lymph Nodes Normal/Abnormal_____
 Heart Normal/Abnormal_____
 Hernia Y / N_____
 Skin Normal/Abnormal_____

Musculoskeletal

Neck Normal/Abnormal_____
 Shoulder Normal/Abnormal_____
 Elbow Normal/Abnormal_____
 Hands Normal/Abnormal_____
 Back Normal/Abnormal_____
 Quad/ham Normal/Abnormal_____
 Ankle Normal/Abnormal_____
 Feet Normal/Abnormal_____
 Heel/toe Normal/Abnormal_____
 Immunizations Given Today_____

PSYCHOSOCIAL

I have discussed high risk behavior and health habits related to physical and sexual changes.

Tobacco Y / N_____
 Alcohol Y / N_____
 Drugs Y / N_____
 Sexual Activity Y / N_____
 Driving Y / N_____
 Seat Belt Y / N_____
 Helmet Y / N_____
 Depression Y / N_____

Participation Status (mark only one answer)

Comments

Full participation for two years_____
 Participation with limitation_____
 Full participation for one year_____
 Participation Denied_____

(Medical Doctor/Doctor of Osteopathy/Nurse Practitioner/Physician Assistant)

Date

Please copy additional forms as needed