# IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

**ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.** Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic,* to the effect that the studen has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes o this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physica examination.*

## QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District _____

Parent's/Guardian's Name _____ Date _____ Phone # _____

Family Physician _____ Phone # _____

***HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)***

| | Yes | No | Does this student have / ever had? |
|---|---|---|---|
| 1. | ____ | ____ | Allergies to medication, pollen, stinging insects, food, etc.? |
| 2. | ____ | ____ | Any illness lasting more than one (1) week? |
| 3. | ____ | ____ | Asthma or difficulty breathing during exercise? |
| 4. | ____ | ____ | Chronic or recurrent illness or injury? |
| 5. | ____ | ____ | Diabetes? |
| 6. | ____ | ____ | Epilepsy or other seizures? |
| 7. | ____ | ____ | Eyeglasses or contacts? |
| 8. | ____ | ____ | Herpes or MRSA? |
| 9. | ____ | ____ | Hospitalizations (Overnight or longer)? |
| 10. | ____ | ____ | Marfan Syndrome? |
| 11. | ____ | ____ | Missing organ (eye, kidney, testicle)? |
| 12. | ____ | ____ | Mononucleosis or Rheumatic fever? |
| 13. | ____ | ____ | Seizures or frequent headaches? |
| 14. | ____ | ____ | Surgery? |
| 15. | ____ | ____ | Chest pressure, pain, or tightness with exercise? |
| 16. | ____ | ____ | Excessive shortness of breath with exercise? |
| 17. | ____ | ____ | Headaches, dizziness or fainting during, or after, exercise? |
| 18. | ____ | ____ | Heart problems (Racing, skipped beats, murmur, infection, etc.?) |
| 19. | ____ | ____ | High blood pressure or high cholesterol? |
| 20. | ____ | ____ | Head injury, concussion, unconsciousness? |
| 21. | ____ | ____ | Headache, memory loss, or confusion with contact? |
| 22. | ____ | ____ | Numbness, tingling or weakness in arms or legs with contact? |
| 23. | ____ | ____ | Severe muscle cramps or illness when exercising in the heat? |
| 24. | ____ | ____ | Fracture, stress fracture or dislocated joint(s)? |
| 25. | ____ | ____ | Injuries requiring medical treatment? |
| 26. | ____ | ____ | Knee injury or surgery? |
| 27. | ____ | ____ | Neck injury? |
| 28. | ____ | ____ | Orthotics, braces, protective equipment? |
| 29. | ____ | ____ | Other serious joint injury? |
| 30. | ____ | ____ | Painful bulge or hernia in the groin area? |
| 31. | ____ | ____ | X-rays, MRI, CT scan, physical therapy? |
| **32.** | ____ | ____ | **Has a doctor ever denied or restricted your participation in sports for any reason?** |
| **33.** | ____ | ____ | **Do you have any concerns you would like to discuss with your health care provider?** |

| | Yes | No | Family History: |
|---|---|---|---|
| 34. | ____ | ____ | Does anyone in your family have Marfan syndrome? |
| 35. | ____ | ____ | Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50? |
| 36. | ____ | ____ | Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? |
| 37. | ____ | ____ | Has anyone in your family had unexplained fainting, seizures, or near drowning? |
| 38. | ____ | ____ | Does anyone in your family have asthma? |
| 39. | ____ | ____ | Do you or someone in your family have sickle cell trait or disease? |

*Use this space to explain any **"YES"** answers from above (questions #1-38) or **to provide any additional information**:*

_____

_____

40. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* _____
41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____
42. Year of last known vaccination: Tetanus: _____ Meningitis: _____ Influenza: _____
43. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least*** _____
44. Are you happy with your current weight? ***Yes*** _____ ***No*** _____ ***If no***, how many pounds would you like to lose or gain?
*Lose* _____ *Gain* _____

## FOR FEMALES ONLY:

How old were you when you had your first menstrual period? _____

How many periods have you had in the last 12 months? _____