# IHSA IESA Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ Sport/Position_____
Last First Middle

Social Security Number_____ School Year_____

Address_____

City/State_____ Phone No._____

Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____

Address_____

Phone No._____

Person to contact in case of emergency_____

Phone No._____

Family Doctor_____ City/State_____

Phone No._____

## Past Medical History

| | | Yes | No | If yes, please explain (what, where, when) |
|---|---|---|---|---|
| 1. | Presently taking medication (including birth control pills)? | | | |
| 2. | Have you been diagnosed with asthma? | | | |
| 3. | Have you been prescribed by a physician to use any asthma medication? | | | |
| 4. | Do you have a current consent form to self-administer the asthma medication on file with your school? | | | |
| 5. | Allergic to medicine, foods, bee stings? | | | |
| 6. | Wears any appliances -- glasses, contact lenses? | | | |
| 7. | History of braces, chipped teeth, bridges? | | | |
| 8. | Has ongoing medical problem? | | | |
| 9. | Had serious or significant illness in past? | | | |
| 10. | Any past surgical operations, accidents, non-sports or related injuries? | | | |
| 11. | Any past injuries directly related to sports? | | | |
| 12. | Any hospitalization not explained above? | | | |
| 13. | Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)? | | | |
| 14. | Any serious family illness (such as diabetes, bleeding disorders, etc.)? | | | |
| 15. | Family history of cancer? | | | |
| 16. | Heart | | | |
| | Have you ever passed out during or after exercise? | | | |
| | Have you ever had chest pain during or after exercise? | | | |
| | Do you get tired more quickly than your friends do during exercise? | | | |
| | Have you ever had racing of your heart or skipped heartbeats? | | | |
| | Have you had high blood pressure or high cholesterol? | | | |
| | Have you ever been told you have a heart murmur? | | | |
| | Has any family member or relative died of heart problems or of sudden death before age 50? | | | |
| | Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? | | | |
| | Has a physician ever denied or restricted your participation in sports for any heart problems? | | | |
| | Has anyone in your family had a heart attack before the age of 50? | | | |
| 17. | Head and Nerve | | | |
| | Have you ever had a head injury or concussion? | | | |
| | Have you ever been knocked out, become unconscious, or lost your memory? | | | |
| | Have you ever had a seizure? | | | |
| | Do you have frequent or severe headaches? | | | |
| | Have you ever had numbness or tingling in your arms, hands, legs or feet? | | | |
| | Have you ever had a stinger, burner, or pinched nerve? | | | |
| 18. | Last tetanus shot? | Date _____ | | |
| 19. | Last eye exam? | Date _____ | | |
| 20. | Last Menstrual period (if women) | Date _____ | | |

## Personal Habits

| | | Yes | No |
|---|---|---|---|
| 1. | Smoking/smokeless tobacco | | |
| 2. | Alcohol/non-medical drugs: marijuana, cocaine, etc. | | |
| 3. | Steroids | | |
| 4. | Easting Disorders – weight loss or gain? | | |

Review of systems (Please check if you have any problems with any of the following areas of your body)

_____ Skin
_____ Head
_____ Eyes
_____ Nose
_____ Mouth/Throat
_____ Nutrition, Weight Control
_____ Neck
_____ Lungs
_____ Heart
_____ Abdomen
_____ Back
_____ Urination, Bowel Control
_____ Genital (including menstrual for women)
_____ Shoulders, Arms, Hands
_____ Hips, Legs, Feet
_____ Muscle–Strength, Feeling
_____ Mental, Emotional
_____ Fatigue
_____ Other: What?

I certify that the above information is correct to the best of my knowledge.

Student Signature_____

Parent/Guardian Signature_____

**Both Student and Parent/Guardian Signatures Are Mandatory**

## Physical Examination

Height_____ Weight_____ Blood Pressure_____

Pulse: resting_____ 15 hops_____ after 2 minutes resting_____

Visual Acuity: Eyes (R) 20/__ w/o glasses_____ (L) 20/_____ w/glasses_____

| Other Testing | Normal | Abnormal Findings |
|---|---|---|
| 1. General | | |
| 2. Skin | | |
| 3. HEENT | | |
| 4. Teeth (Dental Exam) | | |
| 5. Neck | | |
| 6. Lungs | | |
| 7. Heart (Sit and Stand) | | |
| 8. Abdomen | | |
| 9. Genitalia | | |
| 10. Musculoskeletal | | |
| Neck | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand | | |
| Back | | |
| Hip/Thigh | | |
| Knee | | |
| Shin/Calf | | |
| Ankle/Leg | | |
| Foot | | |
| 11. Peripheral Pulses | | |
| 12. Neurologic | | |
| 13. Mental Status | | |
| 14. Marfan Screen | | |

Other Tests (optional)

| | | |
|---|---|---|
| _____ Auditory | _____ U/V | _____ EKG |
| _____ % Body Fat | _____ Drug Screen | _____ Chest X-Ray |
| _____ Hgb/Hct | _____ SMAC | _____ Tanner Stage |

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes_____ No_____ Limited_____

Additional Comments:

Examination Date_____ Physician's Signature_____

Physician's Assistant Signature*_____

Advanced Nurse Practitioner's Signature*_____

*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.

Student's Name_____ School Name_____

## Consent Form to Self-Administer Asthma Medication

**(not needed if current form is already on file with school)**

### Parent Consent

I, _____, do hereby give my son/daughter, _____, Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

_____ _____

Parent's Signature Date

### Physician Consent

As a patient under my care, _____, is prescribed to self-administer the following asthma medication.

Medication_____

Purpose_____

Dosage_____

Time/Special Circumstances_____

_____

_____ _____

Physician's Signature Date

## IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing substances.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

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

_____ _____

Signature of student-athlete Date

_____ _____

Signature of parent-guardian Date

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