ATHLETICS PRE-PARTICIPATION PHYSICAL EXAMINATION
DUBUQUE COMMUNITY SCHOOL DISTRICT

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. Every year each student (grades 6-12) 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 that student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION
(To be completed by the parent. Please type or print this information.)

Name______________________ Male______ Female______ Date of Birth____________ Grade______

Home Address______________________ City____________________ Zip Code____________

Parent's/Guardian's Name____

Home Phone # ____________________ Cell Phone # ______________________________

Family Physician______________________________________ Phone # ________________

Hospital Preference__________________________________ Address__________________

Person to contact if parents/guardian cannot be located_____________________________

Address_____________________________ City/State/Zip Code___________________________

Phone: Work___________________ Home____________________ Date___________________

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 back of this form after the physical examination is completed.)

	Yes	No	Has this student had any?		Yes	No	Has this student had any?
1.			Chronic or recurrent illness or injury?	16.			Asthma?
2.			Any illness lasting more than one (1) week?	17.			Epilepsy or other seizures?
3.			Rheumatic fever, mononucleosis?	18.			Diabetes?
4.			Hospitalizations (Overnight or longer)?	19.			Eyeglasses or contact lenses?
5.			Surgery, other than tonsillectomy?	20.			Dental braces, bridges, plates?
6.			Missing organs (eye, kidney, testicle)?				
7.			Allergy to medications, insects, food?		**Yes**	**No**	**Is there a history of?**
8.			Seasonal allergies (hay fever)?	21.			Injuries requiring medical treatment?
9.			Problems with heart, blood pressure, cholesterol?	22.			Neck injury?
10.			Racing of your heart or skipped heart beats?	23.			Knee injury?
11.			Chest pain with exercise?	24.			Knee surgery?
12.			Frequent headaches, convulsions, dizziness, fainting?	25.			Ankle injury?
13.			Dizziness or fainting with exercise?	26.			Broken bones (fractures)?
14.			Concussion, unconsciousness, extremity numbness?	27.			Other serious joint injuries?
15.			Heat exhaustion, heat stroke, or other heat related problems?	28.			Use of protective equipment or braces?

	Yes	No	Further History
29.			Is there a history of family or genetic disease?
30.			Has any family member died suddenly at less than 40 years of age of causes other than an accident?
31.			Has any family member had a heart attack at less than 55 years of age?
32.			Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping?
33.			List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:
34.	What is the most and least you have weighed in the past year?	Most:	Least:
Date of last known tetanus (lockjaw) shot:		Date of Hepatitis B Series:	

FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period?______________________
2. In the past year, what is the longest time you have gone between menstrual periods?______________

Use this space to explain any of the above numbered YES answers or to provide additional information:________________

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Parent's Section continued on back.

By signing below, I state that I have read and understand the following:

1. I hereby give my permission to an authorized athletic trainer to give medical attention for my child in case of injury or illness.
2. I give my consent for my child to engage in state association approved athletic activities as a representative of his/her school.
3. I give my consent for my child to accompany his/her team as a member on school sponsored transportation to both in and out of town contests.
4. I give my consent for my child to travel to or from a school athletic event by means other than a school vehicle when school transportation is unavailable or impractical. I consent to waive the responsibility of the school district when my son/daughter is being transported by anything other than a school vehicle and/or drivers other than school personnel to or from a school sponsored activity.
5. I have read the "PARTICIPATION CODE FOR ACTIVITIES" that contains regulations for academic eligibility, attendance in school, behavior both in and out of school, and health rules that forbid the use or possession of steroids, alcohol, tobacco, and drugs. I fully understand that my son/daughter may be suspended or dropped from an activity for failure to abide by these rules and regulations.
6. ACKNOWLEDGEMENT OF RISK: I realize that there is a risk of being injured that is inherent in all sports. I realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.
7. EQUIPMENT: In certain sports, practice and game equipment is issued to athletes. As a member of this squad it is expected:
   - All equipment will be checked in by your son/daughter immediately after a sport is finished.
   - He/she will pay for any equipment lost. The coach and building activity's director will determine the price.
   - This equipment is to be worn only at school athletic events and practices. Items from other schools are not to be worn by athletes in our public schools.

______________________________ Typed or printed Name of Parent or Guardian

______________________________ **Signature of Parent or Guardian**

______________________________ Address (Street/PO Box, City, State, Zip Code)

______________________________ Phone Number

______________________________ Date

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PHYSICAL EXAMINATION RECORD

(To be completed by a licensed professional as designated in Article VII 36.14(1).) **This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.**

Athlete's Name______________________________

Height___________ Weight__________ Pulse__________ Blood Pressure_______________ Vision: R 20/_________ L 20/__________

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance (esp. Marfan's)			
Eyes/Ears/Nose/Throat			
Mouth & Teeth			
Neck			
Lymph Nodes			
Heart (Standing & Lying)			
Pulses (esp. Femoral)			
Chest & Lungs			
Abdomen			
Skin			
Genitals – Hernia			
Musculoskeletal – ROM, strength, etc. (See questions 21-27)			
Neurological			
Scoliosis			

Athletic Participation Recommendations:

____ **Full & Unlimited Participation**

____ **Limited Participation** – May **NOT** participate in the following (checked):

____ Baseball _____ Softball
____ Basketball _____ Swimming
____ Bowling _____ Tennis
____ Cheerleader _____ Track
____ Cross Country _____ Volleyball
____ Football _____ Wrestling
____ Golf _____ Other
____ Soccer

____ **Clearance Pending Documented Follow up of** ______________________________

____ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

Comments regarding abnormal findings:______________________________

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Licensed Professional's Name (Printed):______________________________ **Exam Date:**______________________

Licensed Professional's Signature:______________________________ **Phone:**______________________

Revised 10/2009