MHSA CONFIDENTIAL ATHLETIC PREPARTICIPATION PHYSICAL EXAMINATION

Students must have a preparticipation physical examination completed yearly prior to the first practice of any sport. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. While **Logan Health is the preferred medical provider of the MHSA, parents/guardians may choose their own medial provider for their Physical Examination** This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Athlete Name: _____ **Gender**: _____ **Grade**: _____ **Date of Birth**: _____

Home Address: _____ **Phone Number**: _____

Parent/Guardian's Name: _____ **Family Physician**: _____

Date of examination: _____ **Current school**:_____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (i.e. medicines, pollens, food, stinging insects). _____

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of the form. Circle questions if you don't know the answer.)	**YES**	**NO**		**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**	**YES**	**NO**
1. Do you have any concerns that you would like to discuss with your provider?				11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
2. Has a provider ever denied or restricted your participation in sports for any reason?				12 Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
3. Do you have any ongoing medical issues or recent illness?				13. Has anyone in your family had a pacemaker or an Implanted defibrillator before age 35?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**		**BONE AND JOINT QUESTIONS**	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?				14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				15. Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				16. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
7. Has a doctor ever told you that you have any heart problems?				**MEDICAL QUESTIONS**	**YES**	**NO**
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.				17. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				18. Have you ever used an inhaler or taken asthma medicine?		
10. Have you ever had a seizure?				19. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		

MEDICAL QUESTIONS (*CONTINUED*)	YES	NO		ADDITIONAL INFORMATION
20. Do you have groin or testicle pain or a painful bulge or hernia In the groin area?				**Explain any "Yes" responses to questions in the history sections below.**
21. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				
22. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?				
23. Have you ever become ill while exercising in the heat?				
24. Do you or does someone in your family have sickle cell trait or disease?				
25. Have you had or do you have any problems with your eyes or vision?				
26. Have you ever had an eating disorder?				
27. Have you had infectious mononucleosis (mono) within the last Month?				
FEMALES ONLY	**YES**	**NO**		
28. Have you ever had a menstrual period?				
29. How old were you when you had your first menstrual period?				
30. When was your most recent menstrual period?				
31. How many periods have you had in the past 12 months?				

Name of Athlete (typed or printed): _____

Signature of Athlete:_____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Name of Parent/Guardian (typed or printed):_____

Signature of Parent/Guardian:_____

Date:_____ Address: _____ Insurance Company:_____

Parent's Home Phone:_____ Parent's Cell Phone: _____ Parent's Work Phone: _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

PROVIDER'S PHYSICAL EXAMINATION FORM

Athlete Name: _____ **Date of Birth:** _____

EXAMINATION: TO BE FILLED OUT BY MEDICAL PROVIDER ONLY		
Height: _____ Weight:: _____		
Pulse: _____ BP: _____ / _____ Vision: R 20/_____ L 20/_____ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal		
MEDICAL (Please initial)	**NORMAL**	**ABNORMAL FINDINGS**
Appearance (Marfan stigmata)		
Eyes/Ears/Nose/Throat (pupils equal, hearing)		
Lymph Nodes		
Heart (murmurs)		
Pulses (simultaneous femoral and radial)		
Lungs		
Abdomen		
Skin (HSV, MRSA, tinea corporis)		
Neurological		
Genitourinary (males only)		
MUSCULOSKELETAL (Please initial)	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (double-leg squat test, single-leg squat test, box drop or step drop test)		

Notes: _____

_____

_____

CLEARANCE

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports _____ Reason: _____

Recommendations: _____

_____

_____

Name of Physician/Medical Provider [print or type]: _____ Date: _____

Address: _____ Phone:_____

Signature of Physician/Medical Provider: _____

(Updated 4/24)