

The History Form on the back-side of this sheet is to be filled out by the athlete and parent and given to your physician at the time of your scheduled Sports Physical.

At the end of the physical the physician will sign the Physical Examination Form **AND** the Clearance Form if the student athlete is cleared to participate in athletic events.

**Both** the Physical Examination Form and the Clearance Form need to be brought to Paula Symons in the Elementary Office, along with the signed Student Athlete Handbook Acknowledgement Form prior to the student participating in the FIRST practice.



# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/ ( / )	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- Not cleared
- Pending further evaluation
  - For any sports
  - For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician \_\_\_\_\_ MD or DO/PA/APNP

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

## WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ City \_\_\_\_\_

Present Address \_\_\_\_\_ Telephone \_\_\_\_\_

Cleared without restriction       Cleared, with the following qualifications: \_\_\_\_\_

Not cleared       Pending further evaluation       For all sports       For certain sports: \_\_\_\_\_

Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) \_\_\_\_\_

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP\*: \_\_\_\_\_

Clinic Name \_\_\_\_\_

Address/Clinic \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Date of Examination \_\_\_\_\_

\* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment \_\_\_\_\_

Family Physician \_\_\_\_\_ Family Dentist \_\_\_\_\_

Name of Private Insurance Carrier \_\_\_\_\_ Telephone \_\_\_\_\_

Subscriber Member Name (Primary Insured) \_\_\_\_\_

### Emergency Information

Allergies \_\_\_\_\_

Other Information (medication, etc.) \_\_\_\_\_

Immunizations     Up to date (see attached documentation)     Not up to date - specify \_\_\_\_\_

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_