NDHSAA Preparticipation Physical Evaluation Form

Starting with the 2010-11 school year, student athletes participating in NDHSAA sanctioned sports programs will be required to file a pre-participation health history screening and physical examination clearance form (page 4) with their school office prior to their participation on a yearly basis. As per NDHSAA Constitution and By-Laws, physical evaluations may be done by the following medical professionals: Medical Doctor, Doctor of Osteopathy, Physicians Assistant, Nurse Practitioner (MD, DO, PA, NP); the Athletic Pre-Participation Health History Screening and Physical Examination is valid for one school year; a physical examination must be completed on or after * April 15 to be valid for participation the following school year.

The NDHSAA approved form explanations appear below:

To be filled out by Parent/Athlete prior to physical evaluation The medical facility should keep this form.
Special Needs Supplemental History Form
Physical Examination Form
Clearance Form

^{*} Date amended by membership - October 2010

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM - Parent/Athlete fill out prior to physical evaluation

Revised: June 2010 Page 1

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking Do you have any allergies?	ame			Date of birth		
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that caused you to miss a practice or a game? 3. Have you ever had any broken or fractured bones or dislocated joints? 3. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? 3. Have you ever had a stress fracture? 4. Do any of your joints become painful, swollen, feel warm, or look red? Explain "yes" answers here	ONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		_
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9. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? 10. Have you ever had a stress fracture? 11. Have you ever been told that you have or have you had an x-ray for neck instability or attantoaxial instability? (Down syndrome or dwarfism) 2. Do you regularly use a brace, orthotics, or other assistive device? 3. Do you have a bone, muscle, or joint injury that bothers you? 4. Do any of your joints become painful, swollen, feel warm, or look red?				Explain "yes" answers here		
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4. Do any of your joints become painful, swollen, feel warm, or look red?						_

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS:

Revised: June 2010 Page 2

SUPPLEMENTAL HISTORY FORM - Complete ONLY IF special needs athlete.

The medical facility should keep this form. Date of Exam _ Name Date of birth ___ Sex _____ Age ____ Grade ____ School _____ Sport(s) __ 1. Type of disability 2. Date of disability 3. Classification (if available) 4. Cause of disability (birth, disease, accident/trauma, other) 5. List the sports you are interested in playing No 6. Do you regularly use a brace, assistive device, or prosthetic? 7. Do you use any special brace or assistive device for sports? 8. Do you have any rashes, pressure sores, or any other skin problems? 9. Do you have a hearing loss? Do you use a hearing aid? 10. Do you have a visual impairment? 11. Do you use any special devices for bowel or bladder function? 12. Do you have burning or discomfort when urinating? 13. Have you had autonomic dysreflexia? 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? 15. Do you have muscle spasticity? 16. Do you have frequent seizures that cannot be controlled by medication? Explain "yes" answers here Please indicate if you have ever had any of the following. Yes No Atlantoaxial instability X-ray evaluation for atlantoaxial instability Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or hands Numbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy Explain "yes" answers here I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of athlete Signature of parent/guardian

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

Revised: June 2010 Page 3

PHYSICAL EXAMINATION FORM - The medical facility should keep this form.

Name Date of birth

PHYSICIAN REMINDERS

- 1. 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?

z. Consider reviewing ques	olions on cai	uiovascuiai	symptoms (que	5110115 5-14).			
EXAMINATION							
Height		Weigh	t	☐ Male	☐ Female		
BP /	(/)	Pulse	Vision	R 20/	L 20/	Corrected □ Y □ N
MEDICAL	`	<u>, , , , , , , , , , , , , , , , , , , </u>			NORMAL		ABNORMAL FINDINGS
Appearance							
 Marfan stigmata (kypho arm span > height, hyp 							
Eyes/ears/nose/throat							
Pupils equal							
Hearing							
Lymph nodes							
Heart a Murmurs (auscultation Location of point of ma	0,		ılsalva)				
Pulses		,					
Simultaneous femoral a	and radial pu	ılses					
Lungs							
Abdomen							
Genitourinary (males only)	b						
Skin • HSV, lesions suggestive	of MRSA, ti	nea corporis	3				
Neurologic ^c							
MUSCULOSKELETAL							
Neck							
Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							
Hip/thigh							
Knee							
Leg/ankle							
Foot/toes							
Functional							
Duck-walk, single leg h	-						
"Consider ECG, echocardiogram, "Consider GU exam if in private e "Consider cognitive evaluation o Cleared for all sports wi Cleared for all sports wi	setting. Having r baseline neu thout restric	third party propsychiatric t	resent is recomme testing if a history	nded.	ent for		
■ Not cleared							
	uthor	ation					
☐ Pending fi		111011					
☐ For any sp	oorts						
☐ For certain	n sports						
Reason							
Recommendations							
participate in the sport(s)	as outlined te has been	l above. A c cleared fo	opy of the phy r participation,	sical exam is on record in my	office and can be ma	ade available to t	pparent clinical contraindications to practice and ne school at the request of the parents. If condi- red and the potential consequences are completely
Name of MD. DO. PA. N	NP (print/t	vpe)_					Date
Address		. ,					Phone
Signature of MD, DO, PA	4, NP						, MD or D0

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM - Return this page ONLY to school office

Revised: June 2010 Page 4

		Sex 🗆 M 🗆 F Age	Date of Birth	Grade
☐ Cleared for all sports withou	t restriction			
☐ Cleared for all sports withou	t restriction with recommenda	ations for further evaluation or treatment for		
☐ Not cleared				
Pending further	evaluation			
☐ For any sports				
☐ For certain spor	ts			
Reason				
Recommendations				
		npleted the preparticipation physical evalu		
		te in the sport(s) as outlined above. A copy uest of the parents. If conditions arise after		
the physician may rescind		problem is resolved and the potential conse		
(and parents/guardians).				
				Nata
Name of MD, DO, PA, NP (prin	nt/type)			Date
Address			Phone	
Address			Phone	
Address			Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA Allergies	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA Allergies	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA Allergies Other Information	TION		Phone	
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA Allergies Other Information PERMISSION FOR M	TION MEDICAL TREATME	ENT	Phone	, MD or DO
Address Signature of MD, DO, PA, NP EMERGENCY INFORMA Allergies Other Information PERMISSION FOR M In the event of an em	TION MEDICAL TREATME ergency requiring managements.	ENT edical attention, I hereby grant perr	Phone	, MD or DO
AddressSignature of MD, DO, PA, NP EMERGENCY INFORMA Allergies Other Information PERMISSION FOR M In the event of an em daughter/son. I expe	TION MEDICAL TREATME ergency requiring months of the control of t	ENT edical attention, I hereby grant perr	nission for emergenc occurs. I understand	y treatment for my
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