PRE-PARTICIPATION EXAMINATION FORM

Instructions for completing pre-participation (athletic) Health Examination and Consent Form

COMPLETING THIS FORM:

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

QUALIFICATION OF PROVIDERS:

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination must be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician’s Assistant (PAC), or Registered Nurse Practitioner (RNP), or Doctor of Chiropractics (DC), functioning within the legal scope of their practice.

As part of our quality assurance efforts in best practices and maintenance of credentialing, and acknowledging the need to allow time for certification efforts, the BOT approved that all medical personnel that perform the pre-participation physical exam for student athletes will be required to be “Board Certified”* by their respective disciplines by March 10, 2025.

In addition to maintaining the continuing medical education (CME) required by each medical discipline for state licensure, the BOT approved that NPs, PAs, DCs, DOs and MDs have successfully completed postgraduate education and Board Certifications. As examples: NPs would successfully complete and maintain FNP-BC or FNP-C certifications; PAs would successfully complete NCCPA certification and maintain PANRE or PANRE-LA certifications; DCs would successfully complete and maintain a postgraduate Diplomate program (i.e. Internal Medicine & Family, Sports Medicine, Orthopedics, Pediatrics, etc.); DOs and MDs would successfully complete a postgraduate residency/fellowship program and maintain board certification in one of the 24 Member Boards of ABMS.

*Note: The American Board of Medical Specialties differentiates medical licensure from board certification.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.
Pre-Participation Health Examination Form, Updated March 26, 2021

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

Name of Student ___________________________ School ___________________________

Is the student covered by health/accident insurance? □ Yes □ No

Name of health insurance provider ___________________________

If no insurance provider, explain ___________________________

__________________________________________________________

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

● Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.

● Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.

● Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.

● Acknowledge and give consent that a copy of this form will remain in the student’s school. I agree that if my student’s health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.

● Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf

Parent or Guardian Name ___________________________ Parent or Guardian Signature ___________________________

Date ___________________________

Student Statement

By signing below I acknowledge:

● This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.

● My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.

● Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student ___________________________ Date ___________________________

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.
ATHLETIC MEDICAL HISTORY AND PRE-PARTICIPATION EXAM

Must be completed every school year by the athlete and parent prior to any try-out, practice, or athletic contest

Athlete Name: _______________________________ Date of Birth: _________________________

MEDICAL HISTORY

Medications: Please list all of the prescription and over-the-counter medicine and supplements (herbal and nutritional) that you are currently taking

Allergies: Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy.
☐ Medicines ☐ Pollens ☐ Stinging Insects ☐ Food ☐ Pollens

ANY "YES" RESPONSES MUST BE EXPLAINED IN FULL AFTER EACH QUESTION IN THE SPACE

GENERAL QUESTIONS

Yes ☐ No ☐

MEDICAL QUESTIONS

Yes ☐ No ☐

Has a doctor ever denied or restricted your participation in sports for any reason?

Do you cough, wheeze or have difficulty breathing during or after exercise?

Have you ever had asthma or any other chronic breathing problem?

Have you had any problems with your eyes or vision?

Has a doctor ever told you that you have any heart problems? If so check all that apply:
☐ High Blood Pressure ☐ Heart Murmur ☐ Other:

Do you have a history of seizure disorder?

Does anyone in your family have a heart problem, pacemaker, or implanted Defibrillator?

HEART HEALTH QUESTIONS ABOUT YOU

Yes ☐ No ☐

Have you ever had discomfort, pain, tightness, or pressure in your chest during or after exercise?

Have you ever passed out or nearly passed out during or after exercise?

Do you have any rashes, pressure sores, or other skin problems?

Have you ever had any broken, fractured or dislocated bones?

Do you have headaches with exercise?

Do you get frequent muscle cramps when exercising?

BONE AND JOINT QUESTIONS

Yes ☐ No ☐

Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?

Do you get more tired or short of breath more quickly than your friends during exercise?

Have you ever had a stress fracture?

Do you have any joint problems?

Do you have any history of juvenile arthritis, or connective tissue disease?

HEAL AND NECK HEALTH QUESTIONS

Yes ☐ No ☐

Do you have headaches with exercise?

Have you ever had a head injury or concussion?

Do you have a history of head injuries?

FEMALES ONLY

When was your most recent menstrual period?

When was your first menstrual period (age when started)?

How many periods have you had in the last year?

How many periods did you have this year?

What was the longest time between periods in the last year?

When was your first period?
ATHLETIC MEDICAL HISTORY AND PRE-PARTICIPATION EXAM

Must be completed every school year by the athlete and parent prior to any try-out, practice, or athletic contest

NOTE: If a student athlete is under specific medical management (i.e. medications, etc.) the appropriate medical provider will conduct the pre-participation physical exam as these issues will be appropriately addressed during the exam.

ATHLETE INFORMATION

Athlete Name: ____________________________ Date of Exam: ________________

Sport(s): ________________________________

Birth date: ______________ Age: _______ Grade in school _______ Gender: _______ School year: ___________

Athlete Cell Phone No. (_______)_________________ Athlete Address: ____________________________________

EXAMINATION: TO BE FILLED OUT BY PHYSICIAN ONLY

<table>
<thead>
<tr>
<th>Height: _____</th>
<th>Weight: _____</th>
<th>□ Male</th>
<th>□ Female</th>
<th>Pulse: _____</th>
<th>BP: <em><strong><strong>/</strong></strong></em></th>
<th>% Body Fat (opt) _____</th>
</tr>
</thead>
</table>

Vision: Left_____ / Right______/______
Corrected: □ Yes □ No
Pupils: □ Equal □ Unequal

Immunizations: Tetanus ____________ MMR ______________ Hep B ______________ Chickenpox ____________

GENERAL MEDICAL (please initial)

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance (Marfan stigmata)</td>
<td>Neck</td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat (Pupils Equal, Hearing)</td>
<td>Back</td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>Shoulder/Arm</td>
</tr>
<tr>
<td>Heart (murmurs)</td>
<td>Elbow/Forearm</td>
</tr>
<tr>
<td>Pulses (Simultaneous femoral and radial pulses)</td>
<td>Wrist/Hand/Fingers</td>
</tr>
<tr>
<td>Lungs</td>
<td>Hip/Thigh</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Knee</td>
</tr>
<tr>
<td>Skin (HSV, MRSA, tinea corporis)</td>
<td>Leg/Ankle</td>
</tr>
<tr>
<td>Neurological</td>
<td>Foot/Toes</td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
<td>Functional (Duck walk, single leg hop)</td>
</tr>
</tbody>
</table>

MUSCULOSKELETAL (please initial)

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
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ATHLETIC PARTICIPATION RECOMMENDATIONS

<table>
<thead>
<tr>
<th>FULL &amp; UNLIMITED PARTICIPATION</th>
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<tr>
<th>LIMITED PARTICIPATION—May NOT participate in the following</th>
</tr>
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<table>
<thead>
<tr>
<th>CLEARED PENDING—Documented follow up of:</th>
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</table>

<table>
<thead>
<tr>
<th>NOT CLEARED FOR ATHLETIC PARTICIPATION</th>
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Physician’s Comments:

By signing this form, I acknowledge that I am board certified in a medical specialty, and as such, I am current in my maintenance of credentialing.

Medical Provider: ____________________________
(Please print)
Medical Signature: __________________ Date: _______

IF THIS FORM IS NOT FULLY COMPLETED INCLUDING DOCTOR ADDRESS AND NUMBER, IT WILL NOT BE ACCEPTED

Physician’s Office Address

Telephone: (___) __________________