

# Morning Star Academy Pre-Participation Physical Examination

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Article VII 36.14(1) Physical Exam. Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon or osteopath, qualified chiropractor, physicians assistant, or advanced registered nurse practitioner to the effect that the student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purpose of this rule for one calendar year. A grace period not to exceed 30 days is allowed for expired certifications of physical examination.

## Questionnaire for Athletic Participation (PLEASE PRINT)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

GRADE (Please Check the Grade you will be in for the 2009/2010 school year.)

\_\_\_ Freshmen \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER \_\_\_ Male \_\_\_ Female

### PLANNED PARTICIPATION

(Please name the Sport you will participate in each of the seasons, if you will not be participating in that season leave it blank.)

Fall \_\_\_\_\_ Winter \_\_\_\_\_ Spring \_\_\_\_\_

HOME/STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_ PHONE # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

PARENT/GUARDIAN NAME(S) \_\_\_\_\_ WORK # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ EMERGENCY # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHYSICIAN OFFICE # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

### HEALTH HISTORY

Please check Yes or No as it pertains to the student athlete.

- | Yes     | No  | Has this student had any?                               |  |
|---------|-----|---|--|
| 1. ___  | ___ | Chronic or recurrent illness?                           | 27. ___ ___ Has any family member died suddenly at less than 40 years of age of causes other than an accident?         |
| 2. ___  | ___ | Hospitalizations?                                       |  |
| 3. ___  | ___ | Surgery, other than tonsillectomy?                      | 28. ___ ___ Has any family member had a heart attack at less than 55 years of age?                                     |
| 4. ___  | ___ | Missing organs (eye, kidney, testicle)?                 |  |
| 5. ___  | ___ | Allergy to medications?                                 | 29. ___ ___ Are you uncomfortably short of breath after running 1/2 mile (2 times around the track with out stopping)? |
| 6. ___  | ___ | Problems with heart or blood pressure?                  |  |
| 7. ___  | ___ | Chest pain with exercise?                               | 30. List all Medications you are currently taking and for what conditions.   |
| 8. ___  | ___ | Dizziness or fainting with exercise?                    | _____  |
| 9. ___  | ___ | Frequent headaches, convulsions, dizziness or fainting? | _____  |
| 10. ___ | ___ | Concussion or unconsciousness?                          | _____  |
| 11. ___ | ___ | Heat exhaustion, heat stroke, or other heat problems?   | 31. What is the most and least you have weighed in the last year? MOST _____ LEAST _____                               |
| 12. ___ | ___ | Any illness lasting over a week?                        |  |
| 13. ___ | ___ | Rheumatic fever?  |  |
| 14. ___ | ___ | Asthma?   |  |
| 15. ___ | ___ | Epilepsy?   |  |
| 16. ___ | ___ | Diabetes?   |  |
| 17. ___ | ___ | Eyeglasses or Contact Lenses?                           |  |
| 18. ___ | ___ | Dental braces, bridges, plates?                         |  |
| 19. ___ | ___ | Injuries requiring medical treatment?                   |  |
| 20. ___ | ___ | Neck Injury?  |  |
| 21. ___ | ___ | Knee Injury?  |  |
| 22. ___ | ___ | Knee Surgery?   |  |
| 23. ___ | ___ | Ankle Injury?   |  |
| 24. ___ | ___ | Other serious joint injury?                             |  |
| 25. ___ | ___ | Broken bones (fractures)?                               |  |
| 26. ___ | ___ | Is there any history of family or genetic disease?      |  |

### 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 YES answers above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FULL NAME \_\_\_\_\_ DATE OF PHYSICAL EXAM \_\_\_\_/\_\_\_\_/\_\_\_\_

HEIGHT in Inches \_\_\_\_\_ WEIGHT in Pounds \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ RESTING PULSE \_\_\_\_\_

EXAM	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Eyes			
2. Ears, Nose and Throat			
3. Mouth and Teeth			
4. Neck			
5. Cardiovascular			
6. Chest and Lungs			
7. Abdomen			
8. Skin			
9. Musculoskeletal: ROM			
10. Neurological			
11. Genital Hernia			

DATE OF LAST KNOWN TETANUS SHOT: \_\_\_\_\_

\*\*This date must be provided and be within the last 10 years for your patient to engage in competition.\*\*

**PARTICIPATION RECOMMENDATIONS**

\_\_\_\_\_ Full and Unlimited Participation in Sport of Choice  
 \_\_\_\_\_ CLEARANCE PENDING DOCUMENTED FOLLOW-UP OF \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ **NO ATHLETIC PARTICIPATION IN** \_\_\_\_\_

\_\_\_\_\_  
 Licensed Professional's Name Printed or Stamped

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Licensed Professional

\_\_\_\_\_  
 Office Phone

**Insurance Notice/Parent-Guardian Permission**

The school district does NOT purchase an insurance policy for student athletes. School time insurance is offered at a nominal fee and partially covers all sport **EXCEPT** Football. Football players who purchase school time insurance may also purchase a policy for football at their own additional expense. It is agreed that the cost of any and all treatment for injury or injuries sustained by my son/daughter shall be responsibility of the parent/guardian and that all such costs will be paid by us, thus releasing the schools from all financial obligations. I also am aware that participation in athletic competition may result in serious or fatal injuries.

**\*\*PLEASE CHECK ONE BOX\*\***

We plan to participate in the insurance program offered by the school district, as outlined in the insurance letter available at registration in August. We are aware the insurance is not in effect until the form and payment have been received by the school.

We do NOT wish to participate in school district insurance program, as we have our own insurance and or will assume responsibility and cost for injuries.

**Parent/Guardian Permission and Release**

I hereby give my permission 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 Physicians and Certified Athletic Trainers, or other qualified personnel to give first aid treatment to this student at an athletic event or practice. I also give my permission for student athlete to receive Rehabilitation Services from the Team Physicians and the Certified Athletic Trainers that are employed by the school district.

\_\_\_\_\_  
 Printed Name of Parent/Guardian

\_\_\_\_\_  
 Signature of Parent/Guardian