



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), 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.



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 PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

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

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

Height: _____ Weight: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Pulse: _____ BP: ____/____ % Body Fat (opt) _____
Vision: Left ____/____ Right ____/____ Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pupils: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal
Immunizations: Tetanus _____ MMR _____ Hep B _____ Chickenpox _____	

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

ATHLETIC PARTICIPATION RECOMMENDATIONS (Physician MUST select one item listed below)

- _____ FULL & UNLIMITED PARTICIPATION
- _____ LIMITED PARTICIPATION—May NOT participate in the following _____
- _____ CLEARED PENDING—Documented follow up of: _____
- _____ NOT CLEARED FOR ATHLETIC PARTICIPATION

Physician's Comments: _____

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

Medical Provider: _____

(Please print)

Medical Signature: _____ Date: _____

Providers Address: _____

Providers Phone #: _____

MD DO NP PA

DC: The above named athlete is not currently prescribed medication.

DC: Student is taking medication and I have consulted with the prescribing Physician

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



ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

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

Medicines: 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 _____ Food _____ Stinging Insects _____

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?		
Do you have any ongoing medical conditions? If so please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____			Have you ever used an inhaler or taken asthma medication?		
Have you ever spent the night in the hospital?			Is there anyone in your family who has asthma?		
Have you ever had surgery?			Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?			Have you had infectious mononucleosis (mono) within the last month?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			Do you have any rashes, pressure sores, or other skin problems?		
Does your heart ever race or skip beats (irregular beats) during exercise?			Have you had a herpes or MRSA skin infection?		
Has a doctor ever told you that you have any heart problems? If so check all that Apply: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection <input type="checkbox"/> Other: _____			Do you have a history of seizure disorder?		
Has a doctor ever ordered a test for your heart? (e.g. ECG/EKG, Echocardiogram)?			Have you had any problems with your eyes or vision?		
Do you get light headed or feel more short of breath than expected during exercise?			Have you had any eye injuries?		
Have you ever had an unexplained seizure?			Do you wear glasses or contact lenses?		
Do you get more tired or short of breath more quickly than your friends during exercise?			Do you wear protective eye wear such as goggles, or a face shield?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	Do you worry about your weight?		
Has any family member or relative died of a heart problem or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			Are you trying to or has anyone recommended that you gain or lose weight?		
Does anyone in your family have hypertrophic cardiomyopathy, Long QT syndrome, Short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?			Are you on a special diet or do you avoid certain types of foods?		
Does anyone in your family have a heart problem, pacemaker, or implanted Defibrillator?			Have you ever had an eating disorder?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			HEAT ILLNESS QUESTIONS	Yes	No
BONE AND JOINT QUESTIONS	Yes	No	Have you ever become ill while exercising in the heat?		
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 frequent muscle cramps when exercising?		
Have you ever had any broken, fractured or dislocated bones?			Do you or someone in your family have sickle cell trait or disease?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?			HEAD AND NECK HEALTH QUESTIONS	Yes	No
Have you ever had a stress fracture?			Do you have headaches with exercise?		
Have you ever been told that you have or have you had an x-ray for a neck instability or atlantoaxial instability (down syndrome or dwarfism)?			Have you ever had a head injury or concussion?		
Do you regularly use a brace, orthotics, or other assistive devices?			Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
Do you have a bone, muscle, or joint injury that bothers you?			Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Do any of your joints become painful, swollen, feel warm or look red?			Have you ever been unable to move your arms or legs after being hit or falling?		
Do you have any history of juvenile arthritis, or connective tissue disease?			FEMALES ONLY		
Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? <i>Specify below if yes</i>			When was your first menstrual period (age when started)?		
If yes, check the appropriate box and explain below:			When was your most recent menstrual period?		
<input type="checkbox"/> Head _____ <input type="checkbox"/> Neck _____			How much time do you usually have from the start of one period to the start of another?		
<input type="checkbox"/> Back _____ <input type="checkbox"/> Shoulder _____			How many periods have you had in the last year?		
<input type="checkbox"/> Arm _____ <input type="checkbox"/> Elbow _____			What was the longest time between periods in the last year?		
<input type="checkbox"/> Finger _____ <input type="checkbox"/> Wrist _____					
<input type="checkbox"/> Hand _____ <input type="checkbox"/> Shin/Calf _____					
<input type="checkbox"/> Thigh _____ <input type="checkbox"/> Knee _____					
<input type="checkbox"/> Hip _____ <input type="checkbox"/> Ankle _____					
<input type="checkbox"/> Foot _____					

Parent Signature: _____ **Date:** _____