SIOUX FALLS PUBLIC SCHOOLS PRE-PARTICIPATION MEDICAL HISTORY

Parent/Guardian must complete this form prior to your student participating in athletics.

NAME _____ GRADE _____ DATE OF BIRTH _____
(Fall 2015)

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have an ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does your heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan Syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
18.	Have you had any broken or fractured bones or dislocated joints?		
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		
20.	Have you ever had a stress fracture?		
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.	Is there anyone in your family who has asthma?		
26.	Have you ever used an inhaler or taken asthma medicine?		
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		

		Yes	No
28	Have you had infectious mononucleosis (mono) within the last month?		
29.	Do you have any rashes, pressure sores, or other skin problems?		
30.	Have you had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell anemia?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you unhappy with your weight?		
43,	Are you trying to gain or lose weight?		
44.	Has anyone recommended you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		

Females only:

47.	Have you ever had a menstrual period?		
48.	How old were you when you had your first menstrual period? _____		
49.	How many periods have you had in the last 12 months? _____		

Explain "Yes" answers here: _____

AUTHORIZATION AND CERTIFICATION

As the parent/guardian, my signature (1) authorizes the above named student to participate in athletics and (2) certifies that to the best of my knowledge everything above is complete and correct and with full knowledge of above medical history that the above named student is physically fit to participate in interscholastic athletics for the 2015-16 school year.

_____ 20_____ _____
Date Signature of Parent

Sioux Falls Public Schools Triennial Physical Evaluation

The HEALTHCARE PROVIDER must complete this form before student may participate in interscholastic high school athletics.

I give permission to a health care provider to complete a physical examination on the student named below. Please refer to Pre-Participation Health History page for health history.

Date: _____ **Parent/Guardian Signature:** _____

Student Name: _____ Gender: F ☐ M ☐ School: _____

Student ID #: _____ DOB: _____ Grade (Fall 2015): _____

1. Blood pressure (sitting) _____ / _____ Repeat in 5 minutes, if elevated _____ / _____.
2. Height _____
3. Weight _____

	Normal	Abnormal	Comments
4. Vision 20/_____ (L) 20/ _____ (R)			
5. Head			
6. Mouth (dentures, braces?)			
7. Eyes (contacts?)			
8. Chest/lung			
9. Heart			
a. Heart sounds			
b. Murmurs			
c. Pulse (rad. vs fem.)			
d. Rhythm			
10. Abdomen			
a. Liver or spleen			
b. Masses			
11. Genitalia			
a. Hernias			
b. Testes			
12. Orthopedic			
a. Cervical spine			
b. Shoulder shrug			
c. Deltoid			
d. Arms/elbow			
e. Hands			
f. Hips			
g. Knees			
h. Ankles			
i. Scoliosis			
13. Tanner Maturation Index (Optional)	Circle: I II III IV V		

SPORTS PARTICIPATION RECOMMENDED FOR:

_____ All Sports: collision, contact/endurance, other

_____ Contact/Endurance Sports only due to _____

_____ Other Sports Only due to _____

_____ Sports Participation Not Recommended, due to _____

_____ Approval Withheld Pending evaluation for _____

Definition: [Collision=Football/Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Tennis, Track, Volleyball, Baseball, Softball, Soccer, Swimming, Competition Cheer and Competition Dance]; [Other Sports=Golf/Bowling]

Name of Examiner: _____ **Date:** _____

NOTE: The following licensed medical personnel are qualified to perform the evaluation and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physicians Assistant and licensed Nurse Practitioner.