

North Dakota High School Activities Association
Athletic Pre-participation
Health History Screening and Physical Examination

This form must be completed prior to participation in NDHSAA athletic events. A health history screening and physical examination is required EVERY TWO YEARS, unless the Health History Screening indicates need for more frequent examinations.

Health History Screening (Must be completed prior to the physical examination)

Name _____ Sex _____ Age _____ Date of birth _____
Address _____ Grade _____
Sport(s) you plan to participate in: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Explain "Yes" answers below: (To be completed by student and parent/legal guardian)

- 1. Have you had a medical problem or injury since your last evaluation? Y N
2. Have you ever been hospitalized? Y N
3. Have you ever had surgery? Y N
4. Are you presently taking any medications or pills? (Include vitamins, prescriptions, non-prescriptions) Y N
5. Do you have any allergies (medicine, bees or other stinging insects)? Y N
6. Have you ever passed out during or after exercise? Y N
7. Have you ever been dizzy during or after exercise? Y N
8. Have you ever had chest pain during or after exercise? Y N
9. Do you tire more quickly than your friends during exercise? Y N
10. Have you ever had high blood pressure? Y N
11. Have you ever been told that you have a heart murmur? Y N
12. Have you ever had racing of your heart or skipped heartbeats? Y N
13. Has anyone in your family died of heart problems or a sudden death before age 50? Y N
14. Do you have any skin problems (itching, rashes, acne)? Y N
15. Have you ever had a head injury or suffer from headaches? Y N
16. Have you ever been knocked unconscious? Y N
17. Have you ever had a seizure? Y N
18. Have you ever had a stinger, burner or pinched nerve? Y N
19. Have you had heat or muscle cramps? Y N
20. Have you ever been dizzy or passed out in the heat? Y N
21. Do you have trouble breathing or do you cough during or after activity? Y N
22. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? Y N
23. Have you had any problem with your eyes or vision? Y N
24. Do you wear glasses or contacts or protective eye wear? Y N
25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.) Y N
26. Are there concerns you wish to discuss? Y N

Explain "Yes" answers: _____

- 27. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? (Please check appropriate ones)
Head _____ Shoulder _____ Thigh _____ Neck _____ Elbow _____
Knee _____ Chest _____ Scoliosis _____ Forearm _____ Shin/calf _____
Back _____ Wrist _____ Ankle _____ Hip _____ Hand _____
Foot _____
28. When was your last tetanus shot? _____
29. When was your last measles immunization? _____

FEMALES ONLY

- 30. When was your first menstrual period? _____
31. When was your last menstrual period? _____
32. What was the longest between your periods last year? _____ Are they painful? Y or N

Permission for Medical Treatment: In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association.

I hereby state that to the best of my knowledge, my answers to the above questions are correct. I approve participation in athletic activities. I hereby authorize release of the information contained in this document to School Nurse, Certified Athletic Trainer, A. D., Superintendent or Principal.

Date _____ Signature of athlete _____ Signature of Parent/Guardian _____

Physical Examination (to be completed by a Doctor of Medicine or Osteopathy, Nurse Practitioner or Physician Assistant)

Vision R 20/____ L 20/____
 Anisocoria Y / N
 Ht _____ Wt _____ BP _____ Body Fat % _____ (optional)
Notes

General Appearance

Head Nrl/Abnrl _____
 Eyes Nrl/Abnrl _____
 Ears Nrl/Abnrl _____
 Nose Nrl/Abnrl _____
 Mouth Nrl/Abnrl _____
 Dental Nrl/Abnrl _____
 Thyroid Nrl/Abnrl _____
 Lymph nodes Nrl/Abnrl _____
 Heart Nrl/Abnrl _____
 Lungs Nrl/Abnrl _____
 Hernia Y / N _____
 Skin Nrl/Abnrl _____

Musculoskeletal

Neck Nrl/Abnrl _____
 Shoulder Nrl/Abnrl _____
 Elbow Nrl/Abnrl _____
 Hands Nrl/Abnrl _____
 Back Nrl/Abnrl _____
 Quad/ham Nrl/Abnrl _____
 Ankle Nrl/Abnrl _____
 Feet Nrl/Abnrl _____
 Heel/toe Nrl/Abnrl _____
 Immunizations Given Today _____

PSYCHOSOCIAL

I have discussed high risk behavior and health habits related to physical and sexual changes.

Tobacco Y / N _____
 Alcohol Y / N _____
 Drugs Y / N _____
 Sexual Activity Y / N _____
 Driving Y / N _____
 Seat Belt Y / N _____
 Helmet Y / N _____
 Depression Y / N _____

Participation Status (mark only one answer)

Comments

Full participation for two years _____
 Participation with limitation _____
 Full participation for one year _____
 Participation Denied _____

(Medical Doctor/Doctor of Osteopathy/Nurse Practitioner/Physician Assistant)

Date

Please copy additional forms as needed