

MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)				
Name _____	Male _____	Female _____	Date of Birth _____	Grade _____
Home Address _____			Phone Number _____	
Parent's Name _____		Family Physician _____		
Current School _____				
Date _____		Student's Signature _____		

Explain "Yes" answers below. Circle questions to which you don't know the answer.

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking medicine for ADHD? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever told you that you have (circle all that apply):
High blood pressure A heart murmur
High cholesterol A heart infection | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 35. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 37. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 38. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you had any problems with your eyes or visions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 42. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

21. Have you ever had a stress fracture? Yes No
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
23. Do you regularly use a brace or assistive device? Yes No
24. Has a doctor ever told you that you have asthma or allergies? Yes No

FEMALES ONLY

48. Have you ever had a menstrual period? Yes No

49. How old were you when you had your first menstrual period? Yes No

50. How many periods have you had in the last year? Yes No

Explain "Yes" answers here:

Allergies: _____

Immunizations: (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella) _____

Date of last known tetanus shot: _____