

| To be completed by athlete or parent prior to examinat  | ion.   |
|---|--|
| Name<br>Last First Mid  | Sport/Position   |
|   |  |
| Social Security NumberAddress   | <del></del>  |
|   |  |
| City/State  |  |
| Birthdate Age Class   |  |
| Parent's Name   |  |
| Address   |  |
| Phone No  |  |
| Person to contact in case of emergency  |  |
| Phone No  |  |
| Family Doctor   | City/State   |
| Phone No  |  |
| Past Medical History  | Yes No If yes, please<br>explain (what<br>where, when) |
| <ol> <li>(including birth control pills)?</li> <li>Have you been diagnosed with asthma?</li> <li>Have you been prescribed by a physician to use asthma medication?</li> <li>Do you have a current consent form to self-admithe asthma medication on file with your school?</li> <li>Allergic to medicine, foods, bee stings?</li> <li>Wears any appliances – glasses, contact lenses?</li> <li>History of braces, chipped teeth, bridges?</li> <li>Has ongoing medical problem?</li> <li>Had serious or significant illness in past?</li> <li>Any past surgical operations, accidents, non-sporelated injuries?</li> <li>Any past injuries directly related to sports?</li> <li>Any hospitalization not explained above?</li> <li>Any known deformities (such as curvature of bacheart problems, one kidney, blindness in one ey testicle, etc.)?</li> <li>Any serious family illness (such as diabetes, ble disorders, etc.)?</li> </ol> | orts or  ck, e, one                                    |

|   |                       | Yes          | No           | If yes, please explain (what where, when |
|---|-----------------------|--------------|--------------|--|
| Have you had high blood pressure  | or                    | 163          | INO          | where, when                              |
| high cholesterol?   |                       |              |              |  |
| Have you ever been told you have  |                       |              |              |  |
| Has any family member or relative   |                       |              |              |  |
| problems or of sudden death befor   |                       |              |              |  |
| Have you had a severe viral infecti<br>myocarditis or mononucleosis) with |                       |              |              |  |
| Has a physician ever denied or res  |                       |              |              |  |
| participation in sports for any heart                                     |                       |              |              |  |
| Has anyone in your family had a he  |                       |              |              |  |
| the age of 50?  |                       |              |              |  |
| 17. Head and Nerve  |                       |              |              | -  |
| Have you ever had a head injury o   |                       |              |              |  |
| Have you ever been knocked out,   |                       |              |              |  |
| unconscious, or lost your memory?   | ?                     |              |              |  |
| Have you ever had a seizure?  Do you have frequent or severe he           | adachac?              |              |              |  |
| Have you ever had numbness or ti  |                       |              |              | -  |
| hands, legs or feet?  |                       |              |              |  |
| Have you ever had a stinger, burne nerve?                                 | er, or pinched        |              |              |  |
| 18. Last tetanus shot?  |                       | Date         |              |  |
| 19. Last eye exam?  |                       | Date         |              |  |
| 20. Last Menstrual period (if women)                                      |                       | Date         |              |  |
| Personal Habits   |                       | Yes          | No           |  |
| <ol> <li>Smoking/smokeless tobacco</li> </ol>                             |                       |              |              |  |
| 2. Alcohol/non-medical drugs: marijua                                     | ana, cocaine, etc.    |              |              |  |
| 3. Steroids   |                       |              |              |  |
| 4. Easting Disorders – weight loss or                                     | gain?                 |              |              |  |
| Review of systems (Please check if you h                                  | nave any problems wi  | th any of th | ne following | areas of your                            |
| pody)   | , ,                   | •            | `            |  |
| Skin  | Lungs                 |              |              | oulders, Arms,<br>nds                    |
| Head  | Heart                 | -            |              | s, Legs, Feet                            |
|   | _                     | -            |              | scle-Strength,                           |
| Eyes  | Abdomen               |              |              | eling                                    |
| Nose  | Back                  |              | Me           | ntal, Emotional                          |
| <u>-</u> .  | Urination,            |              | _            |  |
| Mouth/Throat  | Bowel Control         |              | Fat          | tigue                                    |
| Nutrition,<br>Weight Control  | Genital (including    |              | Oth          | or: What?                                |
| WEIGHT COHITOL  | menstrual for wor     |              |              | ner: What?                               |
|   |                       |              |              |  |
| Neck  |                       |              |              |  |
|   | ect to the best of my | knowledge    |              |  |
| Neck  | ect to the best of my | knowledge    |              |  |
| Neck certify that the above information is corr                           | ect to the best of my | knowledge    |              |  |

| Physical Examination  | n                    |                     |                        |                             |
|---|----------------------|---------------------|------------------------|-----------------------------|
| Height  | Weight               | В                   | lood Pressure          |                             |
| Pulse: resting  | 15 hops              | af                  | fter 2 minutes resting |                             |
| Visual Acuity: Eyes (R) 20/   | w/o glasses_         | (L) 20/_            | w/glasses              |                             |
| Other Testing  1. General 2. Skin 3. HEENT 4. Teeth (Dental Exam) 5. Neck 6. Lungs 7. Heart (Sit and Stand) 8. Abdomen 9. Genitalia 10. Musculoskeletal Neck Shoulder/Arm Elbow/Forearm Wrist/Hand Back Hip/Thigh Knee Shin/Calf Ankle/Leg Foot  11. Peripheral Pulses 12. Neurologic 13. Mental Status |                      | rmal                | Abnormal Findings      | 5                           |
| <ol> <li>Marfan Screen</li> <li>Other Tests (optional)</li> </ol>   |                      |                     |                        |                             |
| Auditory  |                      | U/V                 | [                      | EKG                         |
| % Body Fat Hgb/Hct  |                      | Drug Screen<br>SMAC |                        | Chest X-Ray<br>Fanner Stage |
| On the basis of the examina sports for one year.  | ation on this day, I |                     |                        | •                           |
| Yes   | No                   | Li                  | mited                  |                             |
| Additional Comments:  |                      |                     |                        |                             |
| Examination Date  | Physician's S        | ignature            |                        |                             |
| Physi   | cian's Assistant Si  | gnature*            |                        |                             |
| · ·   | se Practitioner's Si |                     |                        |                             |
| *effective January 2003, the  | HSA Board of Di      | rectors approved    | a recommendation,      | consistent with             |

| Student's Name | School Name |
|----------------|-------------|

## Consent Form to Self-Administer Asthma Medication (not needed if current form is already on file with school)

| Paront | Cane | eant |
|--------|------|------|

| archi donochi  |  |
|--|--|
| l,, do hereby g<br>Permission to self-administer his/her asthma<br>athletic competition. | ive my son/daughter,, a medication as prescribed by his/her physician during |
| Parent's Signature   | <br>Date   |
| Physician Consent  |  |
| As a patient under my care,following asthma medication.                                  | , is prescribed to self-administer the                                       |
| Medication   |  |
| Purpose  |  |
| Dosage   |  |
| Time/Special Circumstances   |  |
|  |  |
|  |  |
| Physician's Signature  | Date   |
|  |  |

## **IHSA Steroid Testing Policy Consent to Random Testing**

(This section for high school students only)

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing substances.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA banned drug classes.pdf

| Signature of student-athlete | Date |
|------------------------------|------|
|                              |      |
| Signature of parent-guardian | Date |
|                              |      |



<sup>\*</sup>effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.