ISD 709 Health History & Physical Exam for Grades 7-12 and/or MSHSL Sports Qualifying Physical Exam

Student Name____________________________ Male___ Female___ Date of Birth ___/___/___ Age____ Class of ______

Address________________________________ Home Phone #___________School___________Sports:_______________

Which High School will you be attending? ❒ Central ❒ East ❒ Denfeld ❒ Other ____________________

SECTION 1 HISTORY To be completed by student and parent.

Have you had or do you have: Circle

Abnormal bleeding	Abnormal Bruising	Anemia	Asthma	Broken bones	Bone or Muscle trouble
Chicken Pox	Diabetes	Dislocation	Draining Ear	Ear Aches	Eczema
Epilepsy (Seizures)	Eye Loss	Eye Trouble	Frequent Colds	Frequent Headaches	German Measles(Rubella)
Hay Fever	Hearing Loss	Heart Murmur	Hepatitis	High Blood Pressure	Mononucleosis
Mumps	Nervousness	Palpitations	Pneumonia	Red Measles(Rubeola)	Rheumatic fever
Scarlet Fever	Scoliosis	Seizures	Sickle cell disease	Single Organ	Sprain
Stinger	Stomach trouble	Strep throat	Stress Fracture	Tonsilits	Tuberculosis
Udescended testicle	Viral Myocarditis	Vision Loss	Whooping Cough		

Allergies (Specify)________________________________ Heart Trouble (Specify) ____________________________________

Have you had or do you have: Circle Yes (Y) or No (N)

An injury or illness since your last exam? Y / N
A chronic or ongoing illness or condition? Y / N
Specify ____
Ever been hospitalized? Y / N
Specify ____
Ever had surgery? Y / N
Specify ____
Been restricted from sports for heart problems? Y / N

Ever had a concussion or a head injury? Y / N
How many? ____________________
Been knocked out or had a memory loss? Y / N
How many? ____________________
A severe viral infection in the last month? Y / N
Do you use any special equipment? Y / N
Specify ________________________
Are there other concerns you have? Y / N
Specify __________________________________

List any medication or pills you take None
(Include over-the-counter, vitamins, supplements)____

During or after exercise have or do you ever: Circle Yes (Y) or No (N)

Excessive fatigue with exercise? Y / N
Had a rash or hives develop? Y / N
Fainted or felt dizzy? Y / N
Had chest pain? Y / N
Had shortness of breath? Y / N
Wheeze, cough, or have trouble breathing? Y / N
Had racing heart or skipped heartbeats? Y / N
Do you tire more easily than your friends? Y / N
Become ill from exercising in the heat? Y / N
Had Marfan's Syndrome? Y / N
Have you ever had heat stroke, heat exhaustion, or passed out from the heat? Y / N
In the last year what was your highest weight? ______
In the last year what was your lowest weight? ______
What do you think is your ideal weight? ______

Family history of sudden death? Y / N
Before age 35? ____ Before age 50? ____
Has any family member or relative:
Died of a heart problem before age 35? Y / N
Died of a heart problem before age 50? Y / N
Had heart disease and lived? Y / N
Died with no known reason? Y / N

Female athletes

Do you have regular menstrual periods? Y / N
At what age was your first period? ______
What is the longest time between periods? ______
How many periods did you have in the last year? ______

ASSUMED RISK AGREEMENT Duluth Public Schools

Participation in athletic activities is voluntary and is not a required part of the regular school day program.
I understand that participation of any nature in an athletic activity offered by the school district can be dangerous and could possibly cause serious and disabling injury.

As a student, I have read the statement above and agree to accept responsibility for following rules and regulations established by my coaches and school administration.

Signature of Student ____________________________________Date ______________________________

As a parent, I have read the statement above and fully understand the inherent dangers of participating in sports activities. I hereby give my permission for my student to participate in athletic activities at his or her own risk. I understand that the school district does not provide medical – hospital insurance covering students in the event of injury. I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I authorize the release of information contained in this document to the school nurse, athletic trainer, coaches, medical providers and any other school personnel involved in the care or this student. Upon written request, I may receive a copy of this document for my personal health care provider.

Signature of Parent ____________________________________ Date ______________________________

NOTE: ***ISD 709 requires all students entering 7th and10th grades to have a physical examination if they plan to participate in interscholastic activities.*** This signed statement and athletic physical examination form must be filed with the school activity director one week before the student commences participation in interscholastic or cheerleading activities.

THE ASSUMED RISK AND ATHLETIC PHYSICAL EXAMINATION FORMS ARE VALID FOR THREE (3) YEARS.
This form will be utilized by school nurses and high school athletic/activities director. Confidential health and safety information regarding your student will be shared with other school staff on a need to know basis.

SECTION 2 PHYSICAL EXAM To be completed Physician

Ht _________ Wt ________ BP _____ / _____ Heart rate________ Hgb or Hct_____________ Urine___________ Arm Span ____________
Vision R 20/_______ L/20________ Glasses Y / N Contact Lenses Y/ N Eye Protection Y / N
Hearing R__________ L__________ Scoliosis Neg._________ Pos. __________ Mouthguard Y / N

HEET

Anisocoria N / Y ______________________ Fundoscopic N / Ab______________________ Ears N / Ab ______________________
Mouth N / Ab ______________________ Throat N / Ab______________________ Dental N / Ab______________________
Thyroid N / Ab ______________________ Lymph nodes N / Ab______________________ Lungs N / Ab______________________
Skin N / Ab ______________________
Heart N / Ab______________________ Murmur N / Ab______________________ Pulses: Radial N / Ab ______________________
Abdomen N / Ab______________________ Genitalia N / Ab______________________ Femoral N /Ab______________________
Tanner Stage I II III IV V Hernia N / Ab______________________ Body Fat (Optional) ______________________

Musculoskeletal Screen

Neck N / Ab Quad / Ham N/ Ab Hands N / Ab Heel / Toe N / Ab Shoulder N / Ab
Back N / Ab Duck Walk N / Ab Elbow N / Ab Feet N / Ab Ankle N / Ab

Notes / List positive findings of complete medical examination: ____
____
____

Immunization History

Minnesota statutes section 121A.15 requires all students who are enrolled in a MN school be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, and hepatitis B. No student is required to receive an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian, or if they have a medical contraindication or laboratory evidence of immunity. To receive this exemption a parent or legal guardian should request an exemption form from the student's school.

Enter the MONTH, DAY & YEAR for all vaccines the pupil received. Do NOT use a check or "X"

Type of Vaccine	1st Dose MM/DD/YY	2nd Dose MM/DD/YY	3rd Dose MM/DD/YY	4th Dose MM/DD/YY	5th Dose MM/DD/YY	6th Dose MM/DD/YY
DPT or TD (Diphtheria, Tetanus & Pertussis)						
Polio						
MMR (Measles, Mumps, Rubella)				**Other Vaccinations Received:** HIB	Hep. A	Varicella
HBV (Hepatitis B Vaccine)						

SECTION 3 SPORTS CLEARANCE To be completed by Physician

I certify that this student has been medically evaluated and is deemed to be physically fit to participate in school interscholastic activities as indicated.
PARTICIPATION CLEARANCE FOR:

All sports Yes / No **Non-contact sports Yes / No** **Collision sports Yes / No** **Contact sports Yes / No**

None Due to: ____

SPORTS CLASSIFICATION (* Not MSHSL Sports)

COLLISION	CONTACT	STRENUOUS	MODERATELY STRENUOUS	NON STRENUOUS	FIELD	SKIING
Football	Basketball	Running	Curling*	Golf	High Jump	X-Country
Hockey	Baseball	Swimming	Badminton*		Pole Vault	Downhill
Soccer	Diving	Tennis	Table Tennis*		Shot Put	
Wrestling	Gymnastics	Weight Lifting*			Discus	
(Basketball)	Softball					
	Volleyball					

Further evaluation required: ___________________________Modifications or exceptions: ______________________________

Print Name of Physician and Clinic:____
____

Physician Signature: ____ **Date of Exam:** ______________________

Valid for 3 years from above dated physician signature **YEAR 2** **YEAR 3**

Rcvd by: ________________________________ ***School Nurse*** ________________________________ ***Athletic Director***