



FORM A

USE THIS FORM FOR INITIAL PHYSICAL EXAM

Instructions for use of pre-participation (athletic)
Health Examination and Consent Form

Instructions for completing FORM A

COMPLETING THIS FORM:

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian with the student are to complete the Health History on page 3 of Form A and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed and the Pre-participation Physical Evaluation (FORM A) must be completed before any student may participate in athletic activities sponsored by this Association. Clearance Form (Form B) must be completed by the parent each subsequent year. A re-evaluation physical examination will be required if any changes appear for questions 1-16 on the Health History form (Form B). Forms A and B along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.

Pre-Participation Physical Evaluation

Health History

Date of Exam _____

Name _____ Age _____ Sex _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ City _____ State _____ Phone _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone(H) _____ Phone(W) _____

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

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have any special or corrective equipment or devices that aren't usually used for your sport or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have an on-going or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	• Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	• Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	• Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below.</i>		
• Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
• Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
• Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
• Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
• Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Foot
• Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	• Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
• Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations:		
• Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
• Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period? _____		
• Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
• Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
• Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
• Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	EXPLAIN ANY YES ANSWERS HERE		
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
• Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
• Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student _____ Signature of Parent _____ Date _____

Pre-Participation Physical Evaluation

Physical Examination

Name _____ Date of Birth _____
 Height _____ Weight _____ % Body Fat (Optional) _____ Pulse _____ BP _____ / _____ (_____ / _____)
 Vision R 20/ _____ L 20/ _____ Corrected Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Stabon-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____ MD, DO, PAC, RNP, DC