STUDENT INFORMATION

TO BE COMPLETED BY THE STUDENT

Student's Name: _____ **Date of Birth** (MM/DD/YYYY): _____

School: _____

Gender at Birth: Male/Female **Preferred Pronouns:** she/her; he/his; they/them

Home Address: _____ **Phone Number:** _____
(Street, City, State, Zip Code)

HEALTH HISTORY

List past and current medical conditions: _____

Have you ever had surgery? If yes, please explain: _____

Do you have allergies? If yes, please list all your allergies: _____

Medications and/or supplements you are currently taking (include over-the-counter) and the condition the medications are for:

_____

HEALTH QUESTIONAIRE

PHQ-4: Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response)

	Not at All	Several Days	Over Half the Days	Nearly Everyday
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

(A sum of > 3 is considered positive on either subscale [Questions 1 and 2 or Questions 3 and 4] for screening purposes)

Score: _____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

GENERAL QUESTIONS

Y | N Do you have any concerns you would like to discuss with your provider?
Y | N Has a provider ever denied or restricted your participation in sport for any reason?
Y | N Do you have any ongoing medical issues or recent illnesses?

HEART HEALTH QUESTIONS

Y | N Have you ever passed out or nearly passed out during or after exercise?
Y | N Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?
Y | N Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?
Y | N Has a doctor ever told you that you have any heart problems?
Y | N Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?
Y | N Do you get lightheaded or feel shorter of breath than your friends during exercise?
Y | N Do you have high blood pressure or high cholesterol?

QUESTIONS ABOUT YOUR FAMILY

Y | N Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
Y | N Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
Y | N Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

CONTINUE TO BACK SIDE →

BONE & JOINT QUESTIONS

Y | N Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?

Y | N Have you had an x-ray, MRI, CT scan or physical therapy for any reason?

Y | N Do you have a bone, muscle, ligament or joint injury that bothers you?

Y | N Do you currently, or have you in the past worn orthotics, braces, or protective equipment for any reason?

MEDICAL QUESTIONS

Y | N Do you cough, wheeze or have difficulty breathing during or after exercise?

Y | N Are you missing a kidney, eye, testicle (male), your spleen or any other organ?

Y | N Do you have groin or testicle pain or a painful bulge or hernia in the groin area?

Y | N Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?

Y | N Have you had a concussion? Or a head injury that caused confusion, a prolonged headache or memory problems?

Y | N Have you ever had a seizure?

Y | N Do you get frequent headaches?

Y | N Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?

Y | N Have you ever become ill when exercising in the heat?

Y | N Do you have sickle cell trait or disease? Or anyone in your family?

Y | N Have you ever had or do you have any problems with your eyes or vision?

Y | N Do you worry about your weight?

Y | N Are you trying or has anyone recommended that you gain or lose weight?

Y | N Are you on a special diet or do you avoid certain types of foods or food groups?

Y | N Have you ever had an eating disorder?

FEMALES ONLY

Y | N Have you ever had a menstrual period? If yes, how old were you when you had your first menstrual period? _____

Y | N When was your most recent menstrual period? _____

Y | N How many periods have you had in the last 12 months? _____

Explain "Yes" answers here: _____

_____

_____

ATTESTATION & CONSENT

› **I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Student's Name (Printed): X _____ **Date** (MM/DD/YYYY): _____

Student's Signature: X _____

› **I hereby state that, to the best of my knowledge, my child's answers to the questions on this form are complete and correct.**

Parent's Name (Printed): X _____ **Date** (MM/DD/YYYY): _____

Parent's Signature: X _____

PHYSICAL EXAMINATION

To be completed by a licensed medical professional as designated in Article VII 36.14(1)

Student's Name: _____

Height: _____ **Weight:** _____ **BP:** ___ / ___ (___ / ___) **Pulse:** _____

Vision: R 20 / ____ **L 20** / ____ **Glasses:** Y / N **Needs Additional Vision Screening:** Y / N

MEDICAL

	Normal	Abnormal Findings
Appearance (Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolaps (MVP), and aortic insufficiency)		
Eyes, Ears, Nose and Throat (Pupils equal & Hearing)		
Lymph Nodes		
Heart and Lungs (Murmurs - auscultation standing, auscultation supine and ± Valsalva)		
Abdomen		
Skin (Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis)		
Neurological		
Musculoskeletal (Neck, Back, Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Leg, Ankle, Foot and Toes)		

Comments/Next steps regarding any abnormal findings: _____

_____

Licensed Medical Professional's Athletic Participation Eligibility

_____ **Full & Unlimited Participation**

_____ **Limited Participation – May NOT participate in the following sports/types of activities:** _____

_____

_____ **Clearance Pending – Needs documented follow-up of:** _____

_____ **NOT CLEARED for Athletic Participation Due to:** _____

Licensed Medical Professional's Name (Printed): X _____

Date (MM/DD/YYYY): _____

Licensed Medical Professional's Signature: X _____

PLEASE SEE CONSENT ON BACK SIDE →

Iowa Athletic Pre-Participation Physical Examination

Article VII.36.14(I) Physical Examination. Students (Grades 7-12) must have a certificate signed by a licensed MD, DO, ARNP or PA indicating the student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purpose of this rule for one (1) calendar year. A grace period, not to exceed 30 days, is allowed for expired certifications.

STUDENT CONSENT

› As a student-athlete with Des Moines Public Schools, I understand that a certificate of physical examination must be presented to the school superintendent or a designated representative in order for me to participate in activities during the school year. I grant permission for the licensed representatives of The Iowa Clinic to perform a sports physical today and understand that for this certificate to be valid, my parent or guardian will be required to sign this form after the examination is complete.

Student's Name (Printed)**:** X _____ **Date** (MM/DD/YYYY)**:** _____

Student's Signature: X _____

PARENT/GUARDIAN & RELEASE

1. As a parent/guardian of the student listed below, I understand that this examination is a general sports physical to ensure my child is safe to engage in school activities and that it does not replace a regularly scheduled well-child examination by our primary care provider.
2. I hereby give my consent for the above student to engage in approved athletic activities as a representative of their school, except those indicated above by the licensed professional.
3. I give permission for the team's physician, certified athletic trainer or other qualified personnel to give first aid treatment to my child at an athletic event in case of injury.
4. I acknowledge and give consent for a copy of this entire form to be kept in my student school record. I agree that if my health changes in any way that would alter this form that I will inform the school as soon as possible.

Parent's Name (Printed)**:** X _____ **Date** (MM/DD/YYYY)**:** _____

Parent's Signature: X _____ **Phone Number:** _____