IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____

Date of Examination: _____ Sport(s): _____

Home Address (Street, City, Zip): _____ School District: _____

Parent's/Guardian's Name: _____ Phone #: _____

Physician: _____ Phone #: _____

History Form:

List past and current medical conditions.

_____

Have you ever had a surgery? If "yes", list all past surgical procedures.

_____

Medicines and Supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (to medicines, pollen, food, stinging insects, etc.)

_____

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

Heart Health Questions:

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

☐ ☐ 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)?

☐ ☐ Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

☐ ☐ Does anyone in your family have asthma?

Bone and 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?

☐ ☐ Have you had an X-ray, MRI, CT scan or physical therapy for any reason?

☐ ☐ Do you have a bone, muscle, ligament or joint injury that bothers you?

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

Medical Question:

Y N

☐ ☐ Do you cough, wheeze or have difficulty breathing during or after exercise?

☐ ☐ Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

☐ ☐ Do you have groin or testicle pain or a painful bulge or hernia in the groin area?

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

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

☐ ☐ Have you ever had a seizure?

☐ ☐ Do you get frequent headaches?

☐ ☐ 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?

☐ ☐ Have you ever become ill when exercising in the heat?

☐ ☐ Do you have sickle cell trait or disease? Or anyone in your family?

☐ ☐ Have you ever had or do you have any problems with your eyes or vision?

☐ ☐ Do you worry about your weight?

☐ ☐ Are you trying to or has anyone recommended that you gain or lose weight?

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

☐ ☐ Have you ever had an eating disorder?

FEMALES only:

Y N

☐ ☐ Have you ever had a menstrual period?

☐ ☐ How old were you when you had your first menstrual period?

☐ ☐ When was your most recent menstrual period?

☐ ☐ How many periods have you had in the last 12 months?

EXPLAIN "Yes" answers here:

_____

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

Signature of Athlete: _____

Signature of Parent or Guardian: _____ Date: _____

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y N

☐ ☐ Do you feel stressed out or under a lot of pressure?
☐ ☐ Do you ever feel sad, hopeless, depressed or anxious?
☐ ☐ Do you feel safe at your home or residence?
☐ ☐ Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?
☐ ☐ Do you drink alcohol or use any other drugs?
☐ ☐ Have you taken prescriptions medications that were not yours or outside of their intended use?
☐ ☐ Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
☐ ☐ Have you ever taken any supplements to help you gain or lose weight or improve your performance?
☐ ☐ Do you wear a seat belt and a helmet?
☐ ☐ Do you use condoms if you are sexually active?

EXAMINATION

Height: _____ Weight: _____

BP: _____ / _____ (____ / ____) Pulse: _____ Vision: R 20/____ L 20/ ____ Corrected Y / N

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal & Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test		

- Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings or a combination of those.

Medical Eligibility Form

Student Athlete Name: _____ Date of Birth: _____ Date of Examination: _____

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible.

Signature of Parent or Guardian: _____ Date: _____

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:

_____

Medications:

_____

Other Information:

_____

Emergency Contacts:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

Participation Eligibility *(To be filled out by medical provider)*

☐ Medically Eligible for sports without restriction.

☐ Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:

_____

☐ Medically eligible for certain sports:

_____

☐ Not medically eligible pending further evaluation

_____

☐ Not medically eligible for any sports

Recommendations:

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional:

_____

East Mills Community School District
Activities Code of Conduct Agreement

Participation in school activities is a privilege. School activities provide the benefits of promoting additional interests and abilities in the students during their school years and for their lifetimes.

Students who participate in extracurricular activities serve as ambassadors of the school district throughout the calendar year, whether away from school or at school. Students who wish to have the privilege of participating in extracurricular activities must conduct themselves in accordance with board policy and must refrain from activities, which are illegal, immoral or unhealthy. Student participation in these activities and organizations is considered by the Board to be a privileged honor since the student represents and depicts the character and integrity of the school and the community. For this reason, a high standard of normal and social behavior is expected. *Students who fail to abide by this policy and the administrative regulations supporting it may be subject to disciplinary measures.*

Below are some highlights of the Good Conduct Policy. Please see the student handbook for the complete policy along with penalties for any violations. Should you or your student have any questions regarding how the Good Conduct Policy will be interpreted, we encourage you to contact the activities director or building principal for clarification.

- Tobacco
  - No student in any athletic program, activity or organization shall use tobacco.
- Alcohol and Controlled Substances
  - No student in any athletic program, activity or organization shall possess (including attendance at an event where alcohol/drug violations occur), use, or transport any alcoholic beverage or controlled substance.
- Violations of Law and Probation
  - No student in any athletic program, activity or organization shall commit a criminal violation (other than minor traffic violations).
- Citizenship
  - No student in any athletic program, activity or organization shall commit repeated violations or serious violation of any written policy, rule or regulation approved by the Board of Education.
- Academic Eligibility
  - Any student who is failing a class will be placed on *academic alert* for two weeks. If at the end of two weeks, the failing grade has not been brought up to passing, the student will be placed on the *ineligibility list* for two weeks.
- Additions
  - Additional requirements and regulations may be issued by the coach/sponsor of each individual activity.

Thank you for taking the time to go through the policy and rules with your family. Again, please feel free to contact the school with any questions. Your signatures below represent your understanding and agreement with the conditions imposed upon students participating in extracurricular activities at East Mills Community School.

Matt Thornburg
Activities Director

Activity Code of Conduct Agreement

My student has permission to participate in activities at East Mills Community School for the upcoming school year. I have read the activity code of conduct and understand the obligation my student is about to make.

_____ _____

Parent/Guardian Signature Date

I, the undersigned, have read and fully understand the rules and regulations, which govern me as an athlete representing East Mills Community Schools. I further understand that this is an extra-curricular activity, and that attendance to all practices and games is a requirement of me as a participant. I agree to follow the code of conduct, not only during the season, but for a period of 12 months.

_____ _____

Student Signature Date

PARENT & ATHLETE CONCUSSION INFORMATION SHEET

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[INSERT YOUR LOGO]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

East Mills Community School District
Student Emergency Info/Insurance Form

This form MUST be returned to the office *BEFORE* you can practice.

Participant Name: _____

DOB: _____ Age: _____

Parent/Guardian Name: _____

Phone: _____

Alternate Emergency Contact: _____

Emergency Contact Phone: _____

Doctor: _____ Phone: _____

Hospital: _____ Phone: _____

Insurance Provider: _____

Subscriber: _____ Policy #: _____

Secondary Insurance (If Applicable): _____

Subscriber: _____ Policy #: _____

_____ _____

Parent/Guardian Signature Date

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age_____ Grade_____ Date of Birth_____ Today's Date _____

Parent's/Guardian's Name_____

Student's Address_____

Parent's/Guardian's Home Phone Number_____

Father's/Guardian's Place of Work_____

Father's/Guardian's Work Phone Number_____

Mother's/Guardian's Place of Work_____

Mother's/Guardian's Work Phone Number_____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

Family Physician_____ Phone_____

Preferred Hospital_____ Phone_____

Family Dentist_____ Phone_____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses __yes __no/Contacts __yes __no/Dentures __yes __no

- OVER PLEASE -

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age_____ Grade_____ Date of Birth_____ Today's Date _____

Parent's/Guardian's Name_____

Student's Address_____

Parent's/Guardian's Home Phone Number_____

Father's/Guardian's Place of Work_____

Father's/Guardian's Work Phone Number_____

Mother's/Guardian's Place of Work_____

Mother's/Guardian's Work Phone Number_____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

Family Physician_____ Phone_____

Preferred Hospital_____ Phone_____

Family Dentist_____ Phone_____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses __yes __no/Contacts __yes __no/Dentures __yes __no

- OVER PLEASE -

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age_____ Grade_____ Date of Birth_____ Today's Date _____

Parent's/Guardian's Name_____

Student's Address_____

Parent's/Guardian's Home Phone Number_____

Father's/Guardian's Place of Work_____

Father's/Guardian's Work Phone Number_____

Mother's/Guardian's Place of Work_____

Mother's/Guardian's Work Phone Number_____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

Family Physician_____ Phone_____

Preferred Hospital_____ Phone_____

Family Dentist_____ Phone_____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses __yes __no/Contacts __yes __no/Dentures __yes __no

- OVER PLEASE -

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) _____

Age_____ Grade_____ Date of Birth_____ Today's Date _____

Parent's/Guardian's Name_____

Student's Address_____

Parent's/Guardian's Home Phone Number_____

Father's/Guardian's Place of Work_____

Father's/Guardian's Work Phone Number_____

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Mother's/Guardian's Work Phone Number_____

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Do you wear: Glasses __yes __no/Contacts __yes __no/Dentures __yes __no

- OVER PLEASE -

ist any known allergies, drug reactions, or other pertinent medical information. Diabetes, seizures, history of head injury with unconsciousness or confusion, nedications, etc.)

Please note and date any new injury information here:

CONSENT FOR MEDICAL TREATMENT

owa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, n the opinion of a physician, the treatment is necessary to prevent leath or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. *This written authorization is granted only after a reasonable effort has been made to contact me (us).*

Date Parent's/Guardian's signature

Consent for Treatment endorsed by the Iowa Chapter of the American Academy of Emergency Physicians

Cards provided by THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE, IA

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