

**Minnesota State High School League
SPORTS QUALIFYING PHYSICAL EXAMINATION**

Student Name: _____

History Circle Yes (Y) or No (N)

Have you or do you have:

- | | |
|---|-------|
| 1. An injury or illness since your last exam? | Y / N |
| 2. A chronic or ongoing illness? | Y / N |
| 3. Ever been hospitalized? | Y / N |
| 4. Ever had surgery? | Y / N |
| 5. Allergies to medications, bee stings, pollens, or foods? | Y / N |
| 6. A heart murmur? | Y / N |
| 7. High blood pressure or hypertension? | Y / N |
| 8. Been restricted from sports for heart problems? | Y / N |
| 9. Ever had a concussion or a head injury? | Y / N |
| 10. Been knocked out or had memory loss? | Y / N |
| 11. Asthma? | Y / N |
| 12. A severe viral infection in the last month? | Y / N |

During or after exercise have or do you ever:


- | | |
|--|-------|
| 13. Excessive fatigue with exercise? | Y / N |
| 14. Had a rash or hives develop? | Y / N |
| 15. Fainted or felt dizzy? | Y / N |
| 16. Had chest pain? | Y / N |
| 17. Had shortness of breath? | Y / N |
| 18. Had racing heart or skipped heartbeats? | Y / N |
| 19. Do you tire more easily than your friends? | Y / N |
| 20. Become ill from exercising in the heat? | Y / N |
| 21. Wheeze, cough, or have trouble breathing? | Y / N |
| 22. 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 |
| Had Marfan's Syndrome? | Y / N |
| 23. In the last year what was your highest weight? | _____ |
| In the last year what was your lowest weight? | _____ |
| 24. What do you think is your ideal weight? | _____ |
| 25. Female athletes | |
| Do you have regular menstrual periods? | Y / N |
| At what age was your first period? | _____ |
| When was your most recent menstrual period? | _____ |
| What is the longest time between periods? | _____ |
| How many periods did you have in the last year? | _____ |

26. Immunization dates:
- | | | | |
|-----|-------|-------------|-------|
| DT | _____ | Hepatitis B | _____ |
| MMR | _____ | Chickenpox | _____ |

27. Have you had? (Circle)
- | | | |
|-------------------|---------------------|----------------------|
| abnormal bleeding | hearing loss | single organ |
| abnormal bruising | hepatitis | sprain |
| anemia | mononucleosis | stinger |
| broken bones | rheumatic fever | stress fractures |
| diabetes | scoliosis | undescended testicle |
| dislocation | seizures | viral myocarditis |
| eye loss | sickle cell disease | vision loss |
28. Do you use any special equipment? Y / N
29. Are there other concerns you have? Y / N
30. List any medication or pills you take None
- (Include over-the-counter, vitamins, supplements)
- _____
- _____

Physical Examination

Ht _____	Wt _____	Arm Span _____	Glasses	Y / N
Vision – R:20/_____	L:20/_____		Contact Lenses	Y / N
Heart Rate _____	BP _____/_____		Eye Protection	Y / N
			Mouthguard	Y / N

HEENT		Notes	Exam Station
Anisocoria	N / Y	_____	Initials
Fundoscopic	Nrl / Abnrl	_____	
Ears	Nrl / Abnrl	_____	
Mouth	Nrl / Abnrl	_____	
Throat	Nrl / Abnrl	_____	
Dental	Nrl / Abnrl	_____	
Thyroid	Nrl / Abnrl	_____	
Lymph nodes	Nrl / Abnrl	_____	
Lungs	Nrl / Abnrl	_____	
Heart	Nrl / Abnrl	_____	
Murmur	Nrl / Abnrl	_____	
Pulses (rad,fem)	Nrl / Abnrl	_____	
Abdomen	Nrl / Abnrl	_____	
Genitalia (male)	Nrl / Abnrl	_____	
Tanner Stage (optional)	I II III IV V	_____	
Hernia	N / Y	_____	
Skin	Nrl / Abnrl	_____	
Body Fat % (optional)		_____	
Musculoskeletal Screen			
Neck	Nrl / Abnrl	Quad/ham	Nrl / Abnrl
Shlder	Nrl / Abnrl	Ankle	Nrl / Abnrl
Elbow	Nrl / Abnrl	Feet	Nrl / Abnrl
Hands	Nrl / Abnrl	Heel/toe	Nrl / Abnrl
Back	Nrl / Abnrl	Duck walk	Nrl / Abnrl

Notes: _____

Immunizations given today: _____

Physician Signature	Date of Exam
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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 approve participation in athletic activities. 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 of this student. Upon written request, I may receive a copy of this document for my personal health care provider.

Parent or Legal Guardian Signature Date

Athlete Signature Date

**Minnesota State High School League
SPORTS QUALIFYING PHYSICAL EXAMINATION**

Student Name: _____ Birthdate: _____ Age: _____ Gender: _____
 Address: _____
 Home Telephone: _____
 School: _____ Grade: _____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to:

[Circle (1) or (2) or (3) below]

- (1) Participate in all school interscholastic activities.**
- (2) Participate in any activity not crossed out below.**

Sport classification based on contact

Collision contact sports	Limited contact sports	Non-contact sports
Adapted Soccer Basketball Diving Football Ice Hockey Lacrosse Soccer Wrestling	Adapted Softball Baseball Cheerleading Field Events high jump pole vault Floor Hockey Gymnastics Alpine Skiing Nordic Ski Racing Softball Volleyball	Adapted Bowling Badminton Dance Team Field discus shot put Golf Running Swimming Synchronized Swimming Tennis Track

Sport classification based on intensity and strenuousness

High intensity High to moderate dynamic High to moderate static	High intensity High to moderate dynamic Low static	High intensity Low dynamic High to moderate static	Low intensity Low dynamic Low static
Basketball Cross Country Running Nordic Ski Racing Alpine Skiing Football Ice Hockey Lacrosse Running Wrestling	Adapted Soccer Adapted Softball Badminton Baseball Dance Team Soccer Softball Swimming Synchronized Swimming Tennis Volleyball	Cheerleading Diving Field Events Gymnastics	Adapted Bowling Golf

Limitations are due to: _____

(3) Requires further evaluation before a final recommendation can be made.

Further evaluation required: _____

Additional recommendations for the school or parents: _____

I have examined the above-named student and completed the sports clearance physical exam as required by the Minnesota State High School League. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents.

Attending Physician (SIGNATURE) : _____ Date of Physical Exam: _____

Attending Physician (PRINT) : _____

Address: _____

KEEP THIS FORM IN THE ATHLETE'S
MEDICAL RECORD AND COPY THIS
SIDE FOR THE ATHLETE TO RETURN
TO THE SCHOOL

Valid for 3 years from above date with a normal Annual Health Questionnaire

Year 2

Year 3