PRE-PARTICIPATION EXAMINATION FORM

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

COMPLETING THIS FORM:
1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 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 annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form 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.
Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

Student Name: ______________________________
Sport(s) ____________________________________
Gender:  M   F   Age: ______
Date of Birth:  ____/____/_______
School Year:___________
Grade Level:  9  10  11  12

Parent Guardian

Name: _________________________________
Relationship: ____________________________
Address: ________________________________
City/State/Zip: ____________________________

Home: _________________________________
Father (work/Cell): ________________________
Mother (work/cell): ________________________

Name on Insurance Policy: _____________________________
Insurance Co: ______________________________________
Insurance Company: ____________________________
Group Plan/Policy Number: _________________________
Physician/Primary Care Center: ______________________
Hospital Preference: _____________________________

Insurance Information

Name: _________________________________
Relationship: ____________________________
Address: ________________________________
City/State/Zip: ____________________________

Home: _________________________________
Athlete Cell: _____________________________
Father (work/Cell): ________________________
Mother (work/cell): ________________________

Name on Insurance Policy: _____________________________
Insurance Co: ______________________________________
Insurance Company: ____________________________
Group Plan/Policy Number: _________________________
Physician/Primary Care Center: ______________________
Hospital Preference: _____________________________

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.

- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.

- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.

- Acknowledge and give consent that a copy of this form will remain in the student’s school. I agree that if my student’s health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.

- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. [http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf](http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf)

Parent or Guardian Name ____________________________
Parent or Guardian Signature ____________________________
Date ____________________________

Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.

- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.

- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student ____________________________
Date ____________________________

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.
### Preparticipation Physical Evaluation

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

#### Medicines and Allergies:
Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have any allergies?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Medicines
- Pollens
- Food
- Stinging Insects

#### Explain “Yes” answers below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>MEDICAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have any ongoing medical conditions? If so, please identify below:
   - Asthma
   - Anemia
   - Diabetes
   - Infections
   - Other:
3. Have you ever spent the night in the hospital?
4. Have you ever had surgery?
5. Have you ever passed out or nearly passed out during or after exercise?
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
7. Does your heart ever race or skip beats (irregular beats) during exercise?
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   - High blood pressure
   - High cholesterol
   - A heart murmur
   - A heart infection
   - Kawasaki disease
   - Other:
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)
10. Do you get lightheaded or feel more short of breath than expected during exercise?
11. Have you ever had an unexplained seizure?
12. Do you get more tired or short of breath more quickly than your friends during exercise?

#### Heart Health Questions About You

<table>
<thead>
<tr>
<th>HEART HEALTH QUESTIONS ABOUT YOU</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

#### Bone and Joint Questions

<table>
<thead>
<tr>
<th>BONE AND JOINT QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
18. Have you ever had any broken or fractured bones or dislocated joints?
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
20. Have you ever had a stress fracture?
21. Have you ever been told that you have or have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarism)
22. Do you regularly use a brace, orthotics, or other assistive device?
23. Do you have a bone, muscle, or joint injury that bothers you?
24. Do any of your joints become painful, swollen, feel warm, or look red?
25. Do you have any history of juvenile arthritis or connective tissue disease?

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

Signature of athlete: ___________________________ Date: ____________
Signature of parent/guardian: ____________________ Date: ____________
### PHYSICAL EXAMINATION FORM

**Name**

**Date of birth**

#### PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - 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, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>□ Male</th>
<th>□ Female</th>
<th>BP</th>
<th>/</th>
<th>(  )</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>□ Y</th>
<th>□ N</th>
</tr>
</thead>
</table>

#### MEDICAL FINDINGS

**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

**Eyes/ears/nose/throat**
- Pupils equal
- Hearing

**Lymph nodes**

**Heart**
- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

**Pulses**
- Simultaneous femoral and radial pulses

**Lungs**

**Abdomen**

**Genitourinary (males only)**

**Skin**
- HSV, lesions suggestive of MRSA, tinea corporis

**Neurologic**

### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder/arm</td>
</tr>
<tr>
<td>Elbow/forearm</td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
</tr>
<tr>
<td>Hip/thigh</td>
</tr>
<tr>
<td>Knee</td>
</tr>
<tr>
<td>Leg/ankle</td>
</tr>
<tr>
<td>Foot/toes</td>
</tr>
<tr>
<td>Functional</td>
</tr>
</tbody>
</table>
- Duck-walk, single leg hop

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Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

Consider GU exam if in private setting. Having third party present is recommended.

Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for __________________________________________

☐ Not cleared

☐ Pending/further evaluation

☐ For any sports

☐ For certain sports

**Reason Recommendations**

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I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

**Name of physician (print/type)**

**Date**

**Address**

**Phone**

**Signature of physician**

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