2017-2018 SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM
Minnesota State High School League

Student Name: ___________________________ Birth Date: __________ Age: _____ Gender: M / F
Address: __________________________________________________________
Home Telephone: ______ - ______ - ________ Mobile Telephone ______ - ______ - ______
School: ___________________________________ Grade: ______ Sports: ___________________

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check Only One Box)

☐ (1) Participate in all school interscholastic activities without restrictions.
☐ (2) Participate in any activity not crossed out below.

☐ (3) Requires further evaluation before a final recommendation can be made.
   Additional recommendations for the school or parents: ____________________________

☐ (4) Not cleared for: ☐ All Sports ☐ Specific Sports ____________________________
   Reason: ____________________________

I have examined the above named student and completed the Sports Qualifying 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 Exam __________
Print Physician Name: ________________________________________________
Office/Clinic Name: __________________________________________________
City, State, Zip Code: ______ - ______ - ______ E-Mail Address: _______________

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 1-2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual)]
☐ Up-to-date (see attached school documentation) ☐ Not reviewed at this visit

IMMUNIZATIONS GIVEN TODAY: ____________________________________________

EMERGENCY INFORMATION

Allergies ____________________________
Other Information ____________________________
Emergency Contact: ____________________________ Relationship ____________________________
Telephone: (H) ______ - ______ - ________ (W) ______ - ______ - ________ (C) ______ - ______ - ________
Personal Physician ____________________________ Office Telephone ______ - ______ - ________

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.

FOR SCHOOL ADMINISTRATION USE: ☐ [Year 2 Normal] ☐ [Year 3 Normal]

## GENERAL QUESTIONS
1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? Y/N
2. Do you have any ongoing medical condition (like diabetes, asthma, anemia, infections)? Y/N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y/N
   - List:
4. Do you have allergies to foods, pollens, dust, animals, or stinging insects? Y/N
5. Have you ever spent the night in a hospital? Y/N
6. Have you ever had surgery? Y/N

## MEDICAL QUESTIONS
- Have you had a hernia in the groin area? Y/N
- Have you ever had a head injury or concussion? Y/N
- If yes, how many times?
- Have you ever had your back broken? Y/N
- How many times?
- Have you ever had any other major surgeries? Y/N
- If yes, how many?

## BONE AND JOINT QUESTIONS
20. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis that caused you to miss a practice or game? Y/N
21. Have you ever had any broken or fractured bones or dislocated joints? Y/N
22. Have you ever had an injury that required x-rays, mri, CT scan, injections, therapy, a brace, a cast, or crutches? Y/N
23. Have you ever had a stress fracture? Y/N
24. Have you ever been told that you have had an x-ray for neck instability or atlantoaxial instability? Y/N
25. Do you have a brace, orthotics, or other assistive device? Y/N
26. Do you have a bone, muscle, or joint injury that bothers you? Y/N
27. Do any of your joints become painful, swollen, feel warm, or look red? Y/N
28. Do you have any history of juvenile arthritis or connective tissue disease? Y/N

## HEART HEALTH QUESTIONS ABOUT YOUR FAMILY
16. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning, unexplained car accident, or unexplained infant death syndrome)? Y/N
17. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, sickle cell trait or disease, or catecholaminergic polymorphic ventricular tachycardia? Y/N
18. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Y/N
19. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Y/N

## MEDICAL QUESTIONS
29. Has a doctor ever told you that you have asthma or allergies? Y/N
30. Do you have a cold, flu, cough, experience chest tightness, or have difficulty breathing during or after exercise? Y/N
31. Is there anyone in your family who has asthma? Y/N
32. Have you or any other member of your family had a heart attack? Y/N
33. Do you develop a rash or hives when you exercise? Y/N
34. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ? Y/N
35. Do you have groin pain or a painful bulge or hernia in the groin area? Y/N
36. Have you had infectious mononucleosis (mono) within the last month? Y/N
37. Do you have any rashes, pressure sores, or other skin problems? Y/N
38. Have you had a herpes or MRSA skin infection? Y/N
39. Have you ever had a head injury or concussion? Y/N
40. Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems? Y/N
41. Do you have a history of seizure disorder? Y/N
42. Do you have headaches with exercise? Y/N
43. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y/N
44. Have you ever been unable to move your arms or legs after being hit or falling? Y/N
45. Have you ever become ill while exercising in the heat? Y/N
46. Do you get frequent muscle cramps when exercising? Y/N
47. Do you or someone in your family have sickle cell trait or disease? Y/N
48. Have you had any problems with your eyes or vision? Y/N
49. Have you had any eye injuries? Y/N
50. Do you wear glasses or contact lenses? Y/N
51. Do you wear protective eyewear, such as goggles or a face shield? Y/N
52. Do you worry about your weight? Y/N
53. Are you trying to gain or lose weight? Y/N
54. Are you on a special diet or do you avoid certain types of foods? Y/N
55. Have you ever had an eating disorder? Y/N
56. Do you have any concerns that you would like to discuss with a doctor? Y/N

## FEMALES ONLY
57. Have you ever had a menstrual period? Y/N
58. How old were you when you had your first menstrual period? __________
59. How many menstrual periods have you had in the last year? __________

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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 and I approve participation in athletic activities.
2017-2018 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM
Minnesota State High School League

Student Name: ____________________________________  Birth Date: __________  Age:____  Gender: M / F

Follow-Up Questions About More Sensitive Issues:
1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette, cigar, or pipe smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had any alcohols, even just one?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
9. Question “Risk Behaviors” like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:
________________________________________________________

MEDICAL EXAM

Height _______  Weight _______  BMI (optional) _______  % Body fat (optional) _______  Arm Span _______
Pulse _______  BP _______ / _______  ( _______ / _______ )
Vision: R 20/_____  L 20/_____  Corrected: Y / N  Contacts: Y / N  Hearing: R____  L____ (Audiogram or confrontation)

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<th>Abnormal Notes</th>
<th>Initials*</th>
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</tr>
<tr>
<td>No Marfan stigmata</td>
<td>Y / N</td>
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<tr>
<td>HEENT</td>
<td>Y / N</td>
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<td>Eyes</td>
<td>Y / N</td>
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<td>Fundoscopic</td>
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<tr>
<td>Pupils</td>
<td>Equal / Unequal</td>
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<tr>
<td>Hearing</td>
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<td>Foot/Toes</td>
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<tr>
<td>Functional (Single Leg Hop or Squat, Box Drop)</td>
<td>Y / N</td>
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* Required Only if Multiple Examiners

Notes: ____________________________________________________________

Assessment:  □ Cleared for sports without restriction  □ Restricted participation (see Clearance Form)
Plan:  Immunizations:  □ Up-to-Date  □ Recommend Annual Flu Shot (Especially for Asthma & winter athletes)  □ Consider HPV series
       □ Immunize if needed (Tdap, meningococcal MCV4, (1-2 doses), 3 HPV, 2 MMR, 3 hep B, 2 hep A, 3-4 Polio, 2 varicella or history of disease)
Health Maintenance:  □ Lifestyle, health, and safety counseling  □ Discussed dental care and mouthguard use
       □ Discussed Lead and TB exposure – (Testing indicated / not indicated)  □ Eye Refraction if indicated

Attending Physician Signature: ___________________________________________  Date: ______________________
Minnesota State High School League

2017-2018 PI ADAPTED ATHLETICS PHYSICAL EXAM FORM Addendum
(Use only for Adapted Athletics - PI Division)

The MSHSL has competitive interscholastic Physically Impaired (PI) competition. Students who are deemed fit to participate in competitive athletics from a MSHSL sports qualifying exam should meet the criteria below to participate in Adapted Athletics – PI Division.

The MSHSL Adapted Athletics PI Division program is specifically intended for students with physical impairments who have medical clearance to compete in competitive athletics. A student is eligible to compete in the PI Division with one of the following criteria:

The student must have a diagnosed and documented impairment specified from one of the two sections below:

(Must be diagnosed and documented by a Physician Physician’s Assistant, and/or Advanced Practice Nurse.)

1. _____ Neuromuscular _____ Postural/Skeletal _____ Traumatic
   _____ Growth _____ Neurological Impairment
   Which: _____ affects Motor Function _____ modifies Gait Patterns
   (Optional) ______ Requires the use of prosthesis or mobility device, including but not limited to canes, crutches, walker or wheelchair.

2. _____ Cardio/Respiratory Impairment that is deemed safe for competitive athletics, but limits the intensity and duration of physical exertion such that sustained activity for over five minutes at 60% of maximum heart rate for age results in physical distress in spite of appropriate management of the health condition.

   (NOTE:) A condition that can be appropriately managed with appropriate medications that eliminate physical or health endurance limitations WILL NOT be considered eligible for adapted athletics.

Specific exclusions to PI competition:

The following health conditions, without coexisting physical impairments as outlined above, do not qualify the student to participate in the PI Division even though some of the conditions below may be considered Health Impairments by an individual’s physician, a student’s school, or government agency. This list is not all-inclusive and the conditions are examples of non-qualifying health conditions; other health conditions that are not listed below may also be non-qualifying for participation in the PI Division.

Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Emotional Behavioral Disorder (EBD), Autism spectrum disorders (including Asperger’s Syndrome), Tourette’s Syndrome, Neurofibromatosis, Asthma, Reactive Airway Disease (RAD), Bronchopulmonary Dysplasia (BPD), Blindness, Deafness, Obesity, Depression, Generalized Anxiety Disorder, Seizure Disorder, or other similar disorders.

Student Name ____________________________________________________________
Attending Physician/Physician Assistant [PRINT] ________________________________
Attending Physician/Physician Assistant [SIGNATURE] ____________________________
Date of Physical Exam ______________________________________________________