## MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1<sup>st</sup> is not valid for participation for the following school year. All information is to remain confidential.

HISTORY - To be completed by the student and parent(s).

				QUES	TIONNA	IRE FOR	RAT	HLE	TIC PARTICIPATION (PLEASE PRINT)		_		
Name									Male Female Grade Date of Birth				
Home	Addres	s							Phone Number				
Paren	rs Nam	e							Family Physician		-		
Currer	nt Schoo								Date				
									Student Signature				
							,				_		
		answers w the ans		Circle que	stions to	which	Yes	No.	25. Do you cough, wheeze, or have difficulty breathing during or after	Yes	N		
									26. Is there anyone in your family who has asthma?		Г		
		er denied or	restricted	your partic	ipation in sp	oorts for							
any reason?  2. Do you have an ongoing medical condition (like diabetes or asthma)?  3. Are you currently taking any prescription or nonprescription						aethma\2							
3. Are yo	u currenti	y taking any	prescription	on or nonpr	escription	aou in idy r	Н	H	or any other organ?  29. Have you had infectious mononucleosis (mono) within the last month?		_		
		nter) medici			•			_					
	_	nedicine for							24 Have your best a book of the state of the	ă	È		
		ergies to me							32. Have you ever had a head injury or concussion?		Ē		
		eassed out o							OA Harris III A A				
	7. Have you ever passed out or nearly passed out AFTER exercise? 8. Have you ever had discomfort, pain, or pressure in your chest during.						H	H					
exercise?									00.11				
9. Does y	our heart	race or skip	beats duri	ing exercise	9?				legs after being hit or falling?		_		
		ver told you			all that apply	y):							
_	i blood pre cholester		A heart A heart						or falling?	_	_		
_		er ordered			(for examp	le. ECG.	П		38. When exercising in the heat, do you have severe muscle cramps or become ill?				
	cardiogra		•		(	,,			20 bles a destantation that	П			
									cell trait or sickle cell disease?	_	_		
13. Does anyone in your family have a heart problem?													
14. Has any family member or relative died of heart problems or of sudden													
death before age 50?  15. Does anyone in your family have Marfan syndrome?								П	49. Ann contribution 11 to 20				
15. Does anyone in your family have Marfan syndrome?  16. Have you ever spent the night in a hospital?									• • • • • •				
		your family have Marfan syndrome?    Jack Solve Weath as googles or a face shield?   Spent the night in a hospital?   Jack Solve Weight?     Had surgery?   Jack Solve Weight?     44. Are you trying to gain or lose weight?     45. Have anyone recommended you change your weight or eating habits?											
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle									46. Do you limit or carefully control what you eat?	5			
	ted area b		to miss a p	practice or	game: ir ye	s, circle			47. Do you have any concerns that you would like to discuss with a doctor?				
		ny broken o	r fractured	bones, or	dislocated j	oints?			48. Have you ever had a menstrual period?	-			
If yes	, circle be	low:						_	49. How old were you when you had your first menstrual period?				
20. Have	you had a	bone or joir	nt injury tha	t required :	x-rays, MRI	, CT,			50. How many periods have you had in the last year?		_		
	ry, mjecuo , circle be	ons, rehabili low:	tation, pny	sical therap	y, a brace,	a cast, or o	rutche	es?	Explain "Yes" answers here:				
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Ch	est			_		
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foo				_		
		ad a stress									_		
		told that you		ave you ha	d an x-ray f	or					-		
		ck) instabilit use a brace		ve device?			_	П			_		
24. Has a	doctor eve	er told you th	nat you hav	ve asthma (	or allergies'	?	H				_		
		•					_	_			_		
Allergies													
Immuniz	ations: (	eg, tetanu	s/diphthe	ria; meas	les, mump	s, rubella	; hep	atitis	A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella)				
Date of la	st knowr	n tetanus s	hot:										

## **PROVIDER'S PHYSICAL EXAMINATION FORM**

Name		Date of Birth											
Height	W	/elght	_ Pul	89		BP: Left Arm/		Right Arm					
Vision R 20/						Unequal							
	NORM	AL			Д	BNORMAL FINDINGS				INITIALS*			
MEDICAL										INTIALS			
Appearance													
Eyes/ears/nose/throat													
Hearing													
Lymph nodes			_					-					
Heart													
Murmurs													
Pulses	_									.*.			
Lungs													
Abdomen													
Hernia													
Skin													
MUSCULOSKELETAL													
Neck													
Back													
Shoulder/arm													
Elbow/forearm													
Wrist/hands/fingers													
Hip/thigh													
Knee													
Leg/ankle													
Foot/toes *Multiple examiner set-u													
□ Cleared without restr	ction	·		CLE	ARAN	 C <u>E</u>							
☐ Cleared with recomm		or further evaluation or	treatmer	nt for:									
☐ Not cleared for ☐ Recommendations:	•	☐ Certain sports				Rea	ason:	·					
Name of physician/me	dical provid	der (print or type)						Date					
Address 1207 2r	d St.	W Roundup.	Mt.	5907	72		Dhene	406-323-3	337				
							Phone .	+00-020-00	337				
Signature of physician	/medical pr						_						
engage in approved ath permission for the team treatment to this student	etic activitie: physician, a at an athleti	I by the student/parent( s as a representative or thletic trainer, or other of ic event in case of injur	s) is acc f his/her qualified v. If emo	curate to to school, e personno ergency s	he best except the late to have	MISSION AND RELEAS of my knowledge. I here nose indicated above by we access to information involving medical action of the given medical care by	eby give the licen provided or treatm	sed professional.  I here as well as to pent is required an	I also give give first a	my aid			
Typed or printed name o	guardian												
Date	Add						Insurance (Company name)						
Parent's Home Phone		Parent's Work Phone		Parent's Cell Phone			Add	Additional Phone (if any-specify)					

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL** 

(Updated 3/10)