Revised 4/13/2022 Page 1 of 5

<u>COPY</u> Medical Eligibility Form for the student to return to the school. <u>KEEP</u> the complete document in the student's medical record.

2022-2023 SPORTS QUALIFYING PHYSICAL EXAMINATION MEDICAL ELIGIBILITY FORM Minnesota State High School League

			Birth Dat	e:	_	
Address:		Mo	ohile Telenk			
School.	<i>;.</i> =	_ -	onie reiebii	lone		
O01001.						
(1) Particip (2) Particip	ate in all school		ities withou low. Spo	nt restrictions		,
Sports Basketball	Sports Baseball	Non-contact Sports Badminton	. High % MVC)	Field Events: Discus Shot Put	Alpine Skiing*† Wrestling*	
Cheerleading Diving	Field Events: High Jump	Bowling Cross Country Running	· ≡ 6 <u></u>	Gymnastics*†		
Football Gymnastics Ice Hockey Lacrosse Alpine Skiing	❖ Pole Vault Floor Hockey Nordic Skiing Softball Volleyball	Dance Team Field Events: Discus Shot Put Golf	Increasing Static Component → → Low (25.95% NVC) (25.95% NAC)	Diving*†	Dance Team Football* Field Events: → High Jump → Pole Vault† Synchronized Swimming† Track — Sprints	Basketball* Ice Hockey* Lacrosse* Nordic Skiing — Freestyle Track — Middle Distance Swimming†
Soccer Wrestling		Swimming Tennis Track	Increasing Stat I. Low (<20% MVC)	Bowling Golf	Baseball* Cheerleading Floor Hockey Softball* Volleyball	Badminton Cross Country Running Nordic Skiing — Classical Soccer* Tennis
		luation before a final	ڪ		volleydali	Track — Long Distance
	nendation can be	e made. ons for the school or		A. Low (<40% Max O ₂)	B. Moderate (40-70% Max O₂)	C. High (>70% Max O₂)
				Incre	easing Dynamic Component 🗲	$\rightarrow \rightarrow \rightarrow \rightarrow$
have examined the stud- League. The athlete doe obysical examination find the athlete has been clear completely explained to the Provider Signature	es not have apparent ol dings are on record in ared for participation, t the athlete (and parent	rm and completed the Sports linical contraindications to pr my office and can be made a the physician may rescind the ts or guardians).	highest in dark total cardiovas sion from: Mar cardiovascula s Qualifying Phyractice and part available to the e clearance un	kest shading. The graduated scular demands. "Danger of tron BJ, Zipes DP. 36th Bether ar abnormalities. J Am Coll College of the state of the special exam as resticipate in the spose school at the receival the problem is	ort(s) as outlined on this quest of the parents. If o	rate, moderate, and high moderate ope occurs. Reprinted with permisdations for competitive athletes with ta State High School of form. A copy of the conditions arise after
Print Provider Name	e:					
City, State, Zip Cod	e		/ ludi 000.			
Office Telephone: _		E-Mail Add	lress:			
history of disease); polio Up to date (s	(3-4 doses); influenza see attached scho GIVEN TODAY:	(MCV4, 2 doses); HPV (3 doses) (annual); COVID-19 (2 dosested documentation)	es, 1 dose)] Not reviewe	d at this visit		
EMERGENCY INFO				· · · · · · · · · · · · · · · · · · ·		
Other Information						
Emergency Contact Telenhone: (H)	rgency Contact: Relationship					
Personal Provider_			Offi	ce Telephone		
This form is valid	for 3 calendar yea	ars from above date wit	th a normal	Annual Health	n Questionnaire.	

Reference: Preparticipation Physical Evaluation (5th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2019.

2022-2023 SPORTS QUALIFYING PHYSICAL HISTORY FORM

Minnesota State High School League

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Date of examination: Sport(s): Sox assigned at brith (F. M., or intersex): How do you identify your gender? (F. M., or other): Bave you had COVID-19? Y / N Have you had a COVID-19 vaccination? Y / N 1, 2, or 3 shots? (circle) 1 2 3 Past and current medical conditions: Have you lover had surgery? If yes, list all past surgeries. Late current medical conditions: Have you lover had surgery? If yes, list all past surgeries. Late current medicines and supplements, prescriptions, over the counter, and herball or nutritional supplements. Da you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). Patient Health Questionnaire Version 4 (PHQ-4) Over the past 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 every day Feeling nervous, anxious, or on edge 0 Not at all Several days Over half the days Nearly every day Feeling nervous, anxious, or on edge 0 (If the sum of responses to questions 1 & 2 o 3 a little interest or pleasure in doing things 0 1 1 2 3 3 Little interest or pleasure in doing things 0 1 1 2 2 3 3 Little interest or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response or pleasure in doing things 0 1 1 2 2 3 3 Little response 0 1 1 2 2 3 3 1 2 2	Name:	, , , ,	, Date	of hirth:			
Past and COVID-19? Y / N Past and current medicines and supplements. Prescriptions, over the counter, and herbal or nutritional supplements. List current medicines and supplements prescriptions, over the counter, and herbal or nutritional supplements. Do you have any altergies? If yes, please list all your altergies (ie, medicines, pollans, food, stinging insects). Patient Health Questionnaire Version 4 (PHQ-4) Over the past 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 every day Feeling nervous, anxious, or on edge 0 1 1 2 3 3 Not being able to stop or control wortying 0 1 1 2 3 3 Teleting down, depressed, or hopeless 0 1 1 2 2 3 Feeling down, depressed, or hopeless 0 1 1 2 2 3 Teleting down, depressed, or hopeless 0 1 1 2 2 3 Teleting down, depressed, or hopeless (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Oscision Numbe(1) of questions for which the answer is unknown. Circle Season Numbe(1) of questions for which the answer is unknown. Circle V for Yes or N for No. CENERAL QUESTIONS 1. Doy unknown any oncomens that you would like to discuss with your provider? Y I N 2. Has a provider ever denied or restricted your participation in sports for any reason? Y I N 3. Doy un have any oncogning medical issues or recent filmes? Y I N 4. Have you ever brill give that by a have any heart problems? No Doy un better the discounted to, misch places and the problems? Y I N 3. Have you ever brill give that by number and the problems? Y I N 4. Have give ever brill give that by number and the problems? Y I N 4. Have give ever brill give that by number and the problems? Y I N 4. Have give ever brill give that by number and the problems? Y I N 5. Have give ever brill give that by number of the problems? Y I N 5. Doy up with give rever lide you that you have any heart problems? Y I N 4. Have you ever brill give that by number of the problems? Y I N 4. Have you ever br	Date of examination:	Natine Date of billin					
Past and current medical conditions: Have you ever had surgery? If yes, list all past surgeries. List current medicines and supplements, prescriptions, over the counter, and herbal or nutritional supplements. Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). Patient Health Questionnaire Version 4 (PHO-4) Over the past 2 weeks, how offen have you been bothered by any of the following problems? (Circle response.) Over the past 2 weeks, how offen have you been bothered by any of the following problems? (Circle response.) Not being able to stop or control worrying 0 1 2 3 Feeling nervous, anxious, or on edge Not at all Several days Over half the days Nearly every day Feeling nervous, anxious, or on edge Not being able to stop or control worrying 0 1 2 3 Feeling down, depressed, or hopeless 0 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, availuate.) Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Not County of the past of	Sex assigned at birth (F, M, or intersex): How do you identify your gender? (F, M, or other):						
Have you ever had surgery? If yes, list all past surgeries. List current medicines and supplements: prescriptions, over the counter, and herbal or nutritional supplements. Patient Health Questionnaire Version 4 (PHQ-4) Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.) Patient Health Questionnaire Version 4 (PHQ-4) Over the past 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 every day Feeling nervous, anxious, or on edge 0 1 2 2 3 Not being able to stop or control wornying 0 1 1 2 3 3 Little interest or pleasure in doing things 0 1 1 2 2 3 Feeling down, depressed, or hopeless 0 1 1 2 2 3 Feeling down, depressed, or hopeless 0 1 1 2 2 3 Feeling down, depressed, or hopeless 0 1 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Circle Question Numbe(1) of questions for which the answer is unknown. Circle Question Numbe(1) of questions for which the answer is unknown. GENERAL QUESTIONS 1 boy on have any concerns that you would like to discuss with your provider? Y IN Number 1 boy on have any concerns that you would like to discuss with your provider? Y IN Number 1 boy on have any concerns that you would like to discuss with your provider? Y IN Number 1 boy on have any concerns that you would like to discuss with your provider? Y IN Number 1 boy on have any concerns that you would like to discuss with your provider? Y IN Number 2 boy on heart ever race, flutter in your chest, or slop beats (regular beats) during exercise? Y IN Number 2 boy on heart ever race, flutter in your chest, or slop beats (regular beats) during exercise? Y IN Number 3 boy on heart ever race, flutter in your chest, or slop beats (regular beats) during exercise? Y IN Number 3 boy on heart ever race, flutter in your chest, or slop beats (regular beats) during exercise? Y IN Number 3 boy on the provider of the problems of heart in your chest during exercise? Y				•	•		
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). Patient Health Questionnaire Version 4 (PHQ-4) Over the past 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 every day Feeling nervous, anxious, or on edge 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Teeling down, depressed, or hopeless 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Feeling down, depressed, or hopeless 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Feeling down, depressed, or hopeless 0 1 1 2 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife interest or pleasure in doing things 0 1 1 2 3 3 Italife 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			ne counter, and he	erbal or nutritional supplem	ents.		
Patient Health Questionnaire Version 4 (PHQ-4) Over the past 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 every day Feeling nervous, anxious, or on edge 0 1 1 2 3 3 Not being able to stop or control worrying 0 1 2 3 3 The patient of the past 2 3 3 Feeling down, depressed, or hopeless 0 1 2 3 3 Feeling down, depressed, or hopeless 0 1 2 3 3 Feeling down, depressed, or hopeless 0 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe(1) of questions for which the answer is unknown. Circle Question Numbe(1) of questions for which the answer is unknown. Circle Season Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Not Note 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.) Feeling nervous, anxious, or on edge 0 1 1 2 3 3 Not being able to stop or control worrying 0 1 2 2 3 Seleging down, depressed, or hopeless 0 1 2 2 3 Seleging down, depressed, or hopeless 0 1 1 2 2 3 Seleging down, depressed, or hopeless 0 1 1 2 2 3 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Note 1 1 2 2 3 3 Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Note 1 2 3 3 Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Note 1 2 3 3 Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Note 1 2 3 3 Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for Note 1 3 3 3 4 are ≥3, evaluate.) Circle Y for Yes or N for Note 1 2 3 3 Circle Y for Yes or N for Note 1 3 3 4 are ≥3, evaluate.) Circle Y for Yes or N for Note 1 2 3 4 are ≥3, evaluate. Circle Y for Yes or N for Note 1 2 3 4 are ≥3, evaluate. Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Y in Note 2 4 are ≥4, evaluate.) Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Note 2 4 are ≥4, evaluate.) Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Note 2 4 are ≥4, evaluate.) Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Note 2 4 are ≥4, evaluate.) (In Note 2 4 are ≥4, evaluate.) Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Note 2 4 are ≥4, evaluate.) Circle Y for Yes or N for Note 1 2 4 are ≥4, evaluate. (In Note 2 4 are ≥4, evaluate.) (In Note 2 4 are ≥4, evaluate.) Circle Question Number 2 4 are ≥4,	——————————————————————————————————————		(10, 1110d1011100, p				
Not at all Several days Over half the days Nearly every day 3 Not being able to stop or control worrying 0 1 2 2 3 Not being able to stop or control worrying 0 1 2 2 3 Not being able to stop or control worrying 0 1 2 2 3 Not being able to stop or control worrying 0 1 2 2 3 Not being able to stop or control worrying 0 1 2 2 3 Seeling down, depressed, or hopeless 0 1 2 2 3 Not being able to stop or pleasure in doing things 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 1 2 2 3 3 Not being down, depressed, or hopeless 0 2 3 2 2 2 3 3 Not being down, depressed,							
Feeling nervous, anxious, or on edge 0 1 2 3 3 Little interest or pleasure in doing things 0 1 2 3 3 Little interest or pleasure in doing things 0 1 2 3 3 Feeling down, depressed, or hopeless 0 1 2 3 3 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe(1) of questions for which the answer is unknown. Circle Question Numbe(1) of questions for which the answer is unknown. Circle Question Numbe(1) of questions for which the answer is unknown. Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for No. GENERAL QUESTIONS GENERAL QUESTIONS GENERAL QUESTIONS A provider ever denied or restricted your participation in sports for any reason?	Over the past 2 weeks, now oπen have you					у	
Not being able to stop or control worrying 0 1 2 3 Ittlefit interest or pleasure in folionity things 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed, or hopeless 0 1 2 2 3 Feeling down, depressed 0 1 2 2 3 Feeling down, depressed, depressed 0 1 2 2 3 Feeling down, depressed, depressed 0 1 2 2 3 Feeling down, depressed, depressed 0 1 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 3 Feeling down, depressed 0 1 2 2 2 2 3 Feeling down, depressed 0 1 2 2 2 2 2 3 Feeling down, depressed 0 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Feeling nervous, anxious, or on edge		1		3		
Little interest or pleasure in doing things 0 1 2 3 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe() of questions for which the answer is unknown. Circle Question Numbe() of questions for which the answer is unknown. Circle Yer Yes or N for No CENERAL QUESTIONS GENERAL QUESTIONS GENERAL QUESTIONS 2. Has a provider ever denied or restricted your participation in sports for any reason? Y/N 2. Has a provider ever denied or restricted your participation in sports for any reason? Y/N HEART HEALTH QUESTIONS ABOUT YOUP HEART HEALTH QUESTIONS ABOUT YOUR pain, lightness, or pressure in your chest during exercise? Y/N 5. Have you ever had discomfort, pain, lightness, or pressure in your chest during exercise? Y/N 6. Have you ever brad discomfort, pain, lightness, or pressure in your chest during exercise? Y/N 7. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y/N 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y/N 10. Have you ever had a seizure? Y/N 11. Has any family member or relative clied of heart problems? Y/N 11. Has any family member or relative clied of heart problems? Y/N 12. Does anyone in your family have a genetic heart problems or had an unexpected or unexplained sudden death before age 35 years (Including drowning or unexplained car crash!)? 12. Does anyone in your family have a genetic heart problems or had an unexpected or unexplained sudden death before age 35 years (Including drowning or unexplained car crash!)? 12. Does anyone in your family have a genetic heart problems such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, entrythymogenic night ventricular tachycardia (CPCYT)? 13. Has anyone in your family have a genetic heart problems such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, or catecholamineripole polymorphic ventricular achicycardia (CPCYT)? 13. Has anyone in your fa		0	1	2	3		
Feeling down, depressed, or hopeless 0 1 2 3 (If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe(1) of questions for which the answer is unknown. Circle Y for Yes or N for No. Circle Y for Yes or N for Yes or Yes or Yes or Yes or Yes or Yes or Y		0	1		3		
(If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.) Circle Question Numbe(1) of questions for which the answer is unknown. CenterAL QUESTIONS 1. Do you have any concerns that you would like to discuss with your provider? Y/N 2. Has a provider ever denied or restricted your participation in sports for any reason? Y/N 3. Do you have passed out or nearly passed out during or after exercise? Y/N 4. Have you ever has discomfort, pain, tightness, or pressure in your chest during exercise? Y/N 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y/N 7. Has a doctor ever fold you that you have any heart problems? 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y/N 9. Do you get light-headed or feel shorter of breath than your friends during exercise? Y/N 1. Has any flamily 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)? Y/N 1. Has any flamily 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)? Y/N 1. Does anyone in your family have a genetic heart problems or had an unexpected or unexplained sudden death before age 35 years (Including drowning or unexplained car crash)? Y/N 1. Does anyone in your family have a genetic heart problems or had an unexpected or unexplained sudden death before age 35 years Y/N 1. Does anyone in your family have age genetic heart problems such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminegic polymorphic ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminegic polymorphic ventricular cardiomyopathy (ARVC), long QT			1		3		
ROENERAL QUESTIONS 1.Do you have any concerns that you would like to discuss with your provider? 2. Has a provider ever denied or restricted your participation in sports for any reason? Y/N 3. Do you have any ongoing medical issues or recent liness? Y/N 4. Have you ever passed out or nearly passed out during or after exercise? Y/N 5. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Y/N 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Y/N 7. Has a doctor ever lot dyo ut hat you have any heart problems? Y/N 8. Has a doctor ever lot dyo ut hat you have any heart problems? Y/N 9. Do you get light-headed or feel shorter of breath than your friends during exercise? Y/N 10. Have you ever had a seizure? Y/N 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowing or unexplained car crash)? 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular tachycardia (CPVT)? 13. Has anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 14. Has anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 15. Has anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 16. Has anyone in your family had a pacemaker or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? Y/N 8DOEA AND JOINT QUESTIONS 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y/N 17. Are you missing a kidney, an eye, a	r coming down, doproceda, or nepolece		sponses to questi	_	evaluate.)		
1.Do you have any concerns that you would like to discuss with your provider? 2. Has a provider ever denied or restricted your participation in sports for any reason? 3. Y/N 3. Do you have any ongoing medical issues or recent illness? 4. Have you ever passed out or nearly passed out during or after evercise? 5. Have you ever had disconfort, pain, lightness, or pressure in your chest during exercise? 5. Have you ever had disconfort, pain, lightness, or pressure in your chest during exercise? 7. Y/N 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? 7. Y/N 7. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 9. Do you get light-headed or foel shorter of breath than your friends during exercise? 9. Y/N 10. Have you ever had a seizure? 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular tachycardia (CPVT)? 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, point, or tendon that caused you to miss a practice or game? 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, point, or tendon that caused you to miss a practice or game? 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? 16. Do you cough, wheeze, or have difficultly breathing during or after exercise? 17. Y/N 18. Do you have a bone		nswer is unknown.			Circle Y for '	Yes or N for	
2. Has a provider ever denied or restricted your participation in sports for any reason?	GENERAL QUESTIONS						
3. Do you have any ongoing medical issues or recent illness? HEART HEALTH QUESTIONS ABOUT YOU! 4. Have you ever passed out or nearly passed out during or after exercise? 5. Have you ever had disconffort, pain, tightness, or pressure in your chest during exercise? 7. Y/N 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? 7. Y/N 7. Has a doctor ever told you that you have any heart problems? 8. Has a doctor ever told you that you have any heart problems? 9. Y/N 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 7. N 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 7. N 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 7. N 8. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowing or unexplained car crash?) 7. N 10. Pose 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)? 8. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 7. Y/N 8. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 7. Y/N 8. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 8. Y/N 9. No NA OND JOINT QUESTIONS 9. Y/N 9. Have you ever had a sitess fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? 9. Y/N 9. Do you have a bone, muscle, ligament, or joint injury that bothers you? 9. Y/N 19. Do you have a pone, muscle, ligament, or joint injury that bothers you? 10. Do you bough,	1.Do you have any concerns that you would like	to discuss with your p	orovider?			Y/N	
4. Have you ever passed out or nearly passed out during or after exercise? 5. Have you ever had discomfort, pain, lightness, or pressure in your chest during exercise? 7. / N 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? 7. / N 7. Has a doctor ever told you that you have any heart problems? 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 7. / N 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 7. / N 9. Do you get light-headed or feel shorter of breath than your friends during exercise? 7. / N 8. HEART HEALTH QUESTIONS ABOUT YOUR FAMILY? 11. 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)? 12. 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)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 7. / N 8. HONE AND JOUNT QUESTIONS 14. 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? 7. / N 8. Do you dough, wheeze, or have difficulty breathing during or after exercise? 7. / N 8. Do you dowed any exercimal skin rashes or rashes that come and go, including hepres or methicillin-resistant Staphylococcus aureus (MRSA)? Y/N 8. Do you have a bone, muscle, ligament, or joint injury that bothers you? 8. Have you ever had one readificulty breathing during or after exercise? 7. / N 8. Do you have any recurring skin rashes or rashes that come and go, including hepres or methicillin-resistant Staphylococcus aureus (MRSA	3. Do you have any ongoing medical issues or re	ecent illness?	for any reason?			Y / N Y / N	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	4 Have you ever passed out or nearly passed or	ut during or after exer	cise?			Y/N	
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Y / N Has a doctor ever told you that you have any heart problems? Y / N Has a doctor ever told you that you have any heart problems? Y / N Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y / N 10. Howe you ever had a seizure? Y / N 11. 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)? Y / N 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long CT syndrome (LOTS), short CT syndrome (SCTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? Y / N 13. Has anyone in your family have a pacemaker or an implanted defibrillator before age 35? Y / N 14. 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? Y / N MEDICAL QUESTIONS 14. Have you ever had a stress fracture or injury that bothers you? MEDICAL QUESTIONS 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? Y / N MEDICAL QUESTIONS 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y / N 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Y / N 18. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N 29. Have you ever head on the past of	5 Have you ever had discomfort pain tightness	or pressure in your	chest during exercis	se?		Y / N	
7. Has a doctor ever told you that you have any heart problems?	6. Does your heart ever race, flutter in your ches	t. or skip beats (irregu	ular beats) during e	xercise?		Y/N	
8. Has a doctor ever requested a test for your hear? For example, electrocardiography (ECG) or echocardiography. 9. Do you get light-headed or feel shorter of breath than your friends during exercise? 9. Y/N 10. Have you ever had a seizure? 11. 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)? 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long CT syndrome (LCTS), short CT syndrome (SCTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 14. 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? 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? 17. Nate you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? 18. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? 19. Have you ever had on unbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? 19. Y/N 20. Have you ever had or do you have any problems with your eyes or vision? 19. Y/N 21. Have you ever had a membruse, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? 19. Y/N 21. Have you ever had an enstrual period? 22. Have you ever had a membruse, tingling, weakness in your arms or legs, or been unable to move yo	7. Has a doctor ever told you that you have any h	neart problems?				Y/N	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	8. Has a doctor ever requested a test for your he	art? For example, ele	ectrocardiography (I	ECG) or echocardiography		Y/N	
10. Have you ever had a seizure?							
11. 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)? Y / N 12. 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)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? Y / N 14. 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? Y / N 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? MEDICAL QUESTIONS 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y / N 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Y / N 18. Do you have agroin or testicle pain or a painful bulge or hernia in the groin area? Y / N 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Y / N 21. Have you ever had numbness, lingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? Y / N 22. Have you ever become ill while exercising in the heat? Y / N 23. Do you does someone in your family have sickle cell trait or disease? Y / N 24. Have you ever had on do you have any problems with your eyes or vision? Y / N 25. Do you worry about your weigh? Y / N 26. Are you trying to or has anyone recommended that you gain or lose weight? Y / N 27. Are you on a special diet or do you avoid certain types of foods or food groups? Y / N 28. Have you ever had a menstrual period? Y / N							
12. 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)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 14. 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? 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? 19. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? 19. Day ou ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? 19. Alave you ever had or do you have any problems with your eyes or vision? 20. Have you ever had or do you have any problems with your eyes or vision? 21. Have you ever had or do you have any problems with your eyes or vision? 22. Have you ever had or do you have any problems with your eyes or vision? 23. Do you or does someone in your family have sickle cell trait or disease? 24. Y/N 25. Do you own yabout your weight? 26. Are you trying to or has anyone recommended that you gain or lose weight? 27. Are you on a special diet or do you avoid certain types of foods or food groups? 28. Have you ever had a menstrual period? 39. Have you ever had an eating disorder? 29. Have you ever had an emstrual period? 30. How old were you when you had in the past 12 months? 20. How many periods have you had in the past 12 months? 21. Howe many periods have you had in the past 12 months? 22. How	11. Has any family member or relative died of he	art problems or had a					
ventricular cardiomyopathy (ARVČ), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? Y/N BONE AND JOINT QUESTIONS 14. 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? Y/N 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? NEDICAL QUESTIONS 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y/N 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Y/N 18. Do you have groin or testicle pain or a painful bulge or hermia in the groin area? Y/N 19. Do you have groin or testicle pain or a painful bulge or hermia in the groin area? Y/N 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Y/N 21. 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? Y/N 22. Have you ever become ill while exercising in the heat? Y/N 23. Do you or does someone in your family have sickle cell trait or disease? Y/N 24. Have you ever had or do you have any problems with your eyes or vision? Y/N 25. Do you worry about your weight? Y/N 26. Are you trying to or has anyone recommended that you gain or lose weight? Y/N 27. Are you on a special diet or do you avoid certain types of foods or food groups? Y/N 28. Have you ever had a menstrual period? Y/N 29. Have you ever had a menstrual period? Y/N 29. Have you ever had a menstrual period? SHALES ONLY Y/N 29. Have you ever had a menstrual period? SHALES ONLY Y/N 29. Have you ever had a menstrual period? SHALES ONLY Y/N 25. Do you worn ost recent menstrual period? SHALES ONLY SHAL	(Including drowning or unexplained car crash)? 12. Does anyone in your family have a genetic here.	eart problem such as	hypertrophic cardio	omvopathy (HCM). Marfan syr	ndrome. arrhythmogen	Y/N iic riaht	
BONE ANĎ JOINT QUESTIÓNS 14. 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?	ventricular cardiomyopathy (ARVC), long Q ventricular tachycardia (CPVT)?	T syndrome (LQTS),	short QT syndrome	e (SQTS), Brugada syndrome,	, or catecholaminergic	polymorphic	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	BONE AND JOINT QUESTIONS	·	•				
MEDICAL QUESTIONS 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	14. Have you ever had a stress fracture or an inj15. Do you have a bone, muscle, ligament, or joi	ury to a bone, muscle nt injury that bothers	e, ligament, joint, or you?	tendon that caused you to mi	ss a practice or game?	?Y / N Y / N	
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	MEDICAL QUESTIONS						
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	17. Are you missing a kidney, an eye, a testicle (males), vour spleen.	or any other organ?	?		Y/N	
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	18. Do you have groin or testicle pain or a painfu	I bulge or hernia in th	ne groin area?			Y/N	
21. 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?	19. Do you have any recurring skin rashes or ras	shes that come and go	o, including herpes	or methicillin-resistant Staphy	lococcus aureus (MRS	SA)? Y/N	
22. Have you ever become ill while exercising in the heat?	20. Have you had a concussion or head injury th	at caused confusion,	a prolonged heada	che, or memory problems?		Y / N	
23. Do you or does someone in your family have sickle cell trait or disease? Y / N 24. Have you ever had or do you have any problems with your eyes or vision? Y / N 25. Do you worry about your weight? Y / N 26. Are you trying to or has anyone recommended that you gain or lose weight? Y / N 27. Are you on a special diet or do you avoid certain types of foods or food groups? Y / N 28. Have you ever had an eating disorder? Y / N 29. Have you ever had a menstrual period? Y / N 30. How old were you when you had your first menstrual period? Y / N 31. When was your most recent menstrual period? Y / N 32. How many periods have you had in the past 12 months? Notes: 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:							
24. Have you ever had or do you have any problems with your eyes or vision?							
25. Do you worry about your weight?	23. Do you or does someone in your family have	sickle cell trait or dis	ease?			Y/N	
26. Are you trying to or has anyone recommended that you gain or lose weight?							
27. Are you on a special diet or do you avoid certain types of foods or food groups?	25. Do you worry about your weight?	ad that you gain ar lac				Y/N	
28. Have you ever had an eating disorder?							
FEMALE'S ONLY 29. Have you ever had a menstrual period?							
30. How old were you when you had your first menstrual period? 31. When was your most recent menstrual period? 32. How many periods have you had in the past 12 months? Notes: 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:	FEMALES ONLY						
31. When was your most recent menstrual period? 32. How many periods have you had in the past 12 months? Notes: 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:	29. Have you ever had a menstrual period?	onetrual period?				Y/N	
32. How many periods have you had in the past 12 months? Notes: 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:							
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:							
Signature of athlete: Signature of parent or guardian:	Notes:						
Signature of athlete: Signature of parent or guardian: Date://	I hereby state that, to the best of my knowledge,	my answers to the qu	uestions on this forr	m are complete and correct.			
	Signature of athlete:		Signature of pare	nt or guardian:			

Revised 4/13/2022 Page 3 of 5

2022-2023 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Minnesota State High School League

Student Name:		Birth Date:	
 Do you feel safe? Have you been hit, kicked, slapped, Have you ever tried cigarette, cigar, During the past 30 days, did you use During the past 30 days, have you have Have you ever taken steroid pills or se Have you ever taken any medication 	ot of pressure that you stop punched, sex pipe, e-cigare e chewing toba ad any alcoho shots without is or supplem s, seatbelts, u	doing some of your usual activities for more than a few days? ually abused, inappropriately touched, or threatened with harm by anyone close to you tee smoking, or vaping, even 1 or 2 puffs? Do you currently smoke? acco, snuff, or dip? ol drinks, even just one? a doctor's prescription? ents to help you gain or lose weight or improve your performance? nprotected sex, domestic violence, drugs, and others.	ı?
		MEDICAL EXAM	
		MI (optional) % Body fat (optional) Arm Span (/) // N Contacts: Y / N Hearing: R L (Audiogram or c	
Exam	Normal	Abnormal Findings	Initials*
Appearance Circle any Marfan stigmata present HEENT Eyes Fundoscopic	\rightarrow	Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
Pupils			
Hearing			
Cardiovasculara			
Describe any murmurs present (standing, supine, +/- Valsalva) Pulses (simultaneous femoral &	\rightarrow		
radial)			
Lungs			
Abdomen			
Tanner Staging (optional) Skin (No HSV, MRSA, Tinea corporis)	Ciricle	I II III IV V	
Musculoskeletal			
Neck Back Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional (Double-leg squat test, single-leg squat test, and box drop or step drop test)			
^a Consider ECG, echocardiogram, and/o	or referral to ca	ardiology for abnormal cardiac history or examination findings * For Multiple Ex	aminers
Additional Notes:			
use		munizations, & safety counseling □ Discussed dental care & mout sting indicated / not indicated) □ Eye Refraction if indicated	hguard
Provider Signature:		Date:	

Revised 4/13/2022 Page 4 of 5

Minnesota State High School League ATHLETE WITH DISABILITIES SUPPLEMENT TO THE ATHLETE HISTORY

Name:	Date of birth:			
1. Type of disability:				
2. Date of disability:				
3. Classification (if available):				
4. Cause of disability (birth, disease, injury, or other):				
5. List the sports you are playing:				
6. Do you regularly use a brace, an assistive device, of	or a prosthetic device for daily activities?	Y / N		
7. Do you use any special brace or assistive device fo	Y / N			
8. Do you have any rashes, pressure sores, or other s	Y / N			
9. Do you have a hearing loss? Do you use a hearing	Y / N			
10. Do you have a visual impairment?	Y / N			
11. Do you use any special devices for bowel or blado	Y / N			
12. Do you have burning or discomfort when urinating	Y / N Y / N			
13. Have you had autonomic dysreflexia?				
14. Have you ever been diagnosed as having a heat-r	Y/N			
15. Do you have muscle spasticity? Y / N				
16. Do you have frequent seizures that cannot be con	trolled by medication?	Y/N		
Explain "Yes" answers here.				
Please indicate whether you have ever had any of	the following conditions:			
Atlantoaxial instability	Y/N			
Radiographic (x-ray) evaluation for atlantoaxial instability	ility Y / N			
Dislocated joints (more than one)	Y/N			
Easy bleeding	Y / N			
Enlarged spleen	Y / N			
Hepatitis	Y / N			
Osteopenia or osteoporosis	Y/N			
Difficulty controlling bowel	Y/N			
Difficulty controlling bladder	Y/N			
Numbness or tingling in arms or hands	Y/N			
Numbness or tingling in legs or feet	Y/N			
Weakness in arms or hands	Y/N			
Weakness in legs or feet	Y/N			
Recent change in coordination	Y/N			
Recent change in ability to walk	Y / N Y / N			
Spina bifida				
Latex allergy Explain "Yes" answers here.	Y/N			
Explain les answers nere.				
I hereby state that, to the best of my knowledge, mand correct.	ny answers to the questions on this form a	e complete		
Signature of athlete: Signa	ture of parent or quardian:			
Date: / /	· [
<u> </u>				

Adapted from 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Revised 4/13/2022 Page 5 of 5

Minnesota State High School League

2022-2023 PI ADAPTED ATHLETICS MEDICAL ELIGIBILITY 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 are medically eligible to compete in competitive athletics. A student is administratively eligible to compete in the PI Division with one of the two 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.) _____ Neuromuscular ____ Postural/Skeletal 1. Traumatic _____ Neurological Impairment Growth 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 Provider (SIGNATURE)

Date of Exam _____