2013-2014 SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM
Minnesota State High School League

Student Name: ___________________________ Birth Date: __________ Age: ______ Gender: M / F
Address: ______________________________________________________________________________________
Home 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: __________________________________________________ Address: _________________________
Office/Clinic Name: __________________________ City, State, Zip Code: ____________ E-Mail Address: ______________________________
Office Telephone: ______ - ______ - ________

IMMUNIZATIONS: (Consider Tdap; meningococcal (MCV4); HPV (3 doses); MMR (2 required); hep B (3 required); varicella (2 required or history of disease); poliomyelitis (IPV); influenza)
☐ Up-to-date (see attached school documentation) ☐ Not up-to-date / Specify ________________________________

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 years from above date with a normal Annual Health Questionnaire.
FOR SCHOOL ADMINISTRATION USE: ☐ [Year 2 Normal] ☐ [Year 3 Normal]

**2013-2014 SPORTS QUALIFYING PHYSICAL HISTORY FORM**

**MINNESOTA STATE HIGH SCHOOL LEAGUE**

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**Student Name:**

**Birth Date:**

**Date of Exam:**

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**Circle Question Number(1) of questions for which the answer is unknown.**

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### 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 medicines, pollens, foods, 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

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### HEART HEALTH QUESTIONS

7. Have you ever passed out or nearly passed out during exercise? .......................................................... Y / N
8. Have you ever had a heart palpitation during exercise? .......................................................... Y / N
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? .......................................................... Y / N
10. Does your heart race or skip beats (irregular beats) during exercise? .......................................................... Y / N
11. Has a doctor ever told you that you have (circle):
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection
   - Rheumatic fever
   - Kawasaki's Disease

12. Have you ever had a heart attack? .......................................................... Y / N
13. Do you get lightheaded or feel more short of breath than expected during exercise? .......................................................... Y / N
14. Do you have a history of heart disease in your family? .......................................................... Y / N
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? .......................................................... Y / N
16. Has anyone in your family had a heart attack, unexplained death, or sudden infant death syndrome? .......................................................... Y / N
17. Does anyone in your family have hyperthyroidism, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, or osteosclerotic polymeric ventricular tachycardia? .......................................................... Y / N
18. Is there anyone in your family who has a history of juvenile arthritis or connective tissue disease? .......................................................... Y / N

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### BONE AND JOINT QUESTIONS

20. Have you ever had an injury, such as a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? .......................................................... Y / N
21. Have you ever had a broken bone or dislocated joints? .......................................................... Y / N
22. Have you ever had an injury that required X-rays, MRIs, CT scans, injections, surgery, or other treatment? .......................................................... Y / N
23. Have you ever had a stress fracture? .......................................................... Y / N
24. Have you ever been told that you have an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) .......................................................... Y / N
25. Do you have a brace, orthotic, 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

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### MEDICAL QUESTIONS

29. Has a doctor ever told you that you have asthma or allergies? .......................................................... Y / N
30. Do you cough, wheeze, 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 ever had an asthma 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 a history of heart problems in your family? .......................................................... Y / N
36. Do you have a genetic skin disorder? .......................................................... Y / N
37. Do you have a history of heart problems in your family? .......................................................... Y / N
38. Have you had an ear 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 loss of consciousness? .......................................................... 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 a heart attack? .......................................................... 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 been told you have an x-ray for neck instability? .......................................................... Y / N
46. Do you have frequent muscle cramps when exercising? .......................................................... Y / N
47. Do you or someone in your family have sickle cell trait or disease? .......................................................... Y / N
48. Do you have any problems with your eyes or vision? .......................................................... Y / N
49. Have you ever had any eye problems? .......................................................... 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 lose or gain 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

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### FEMALES ONLY

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

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**Notes:**

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.

Parent or Legal Guardian Signature

Student-Athlete Signature

Date
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 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 at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor’s prescription?
8. Have you ever taken any 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)

<table>
<thead>
<tr>
<th>Exam</th>
<th>Normal</th>
<th>Abnormal Notes</th>
<th>Initials*</th>
</tr>
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<tbody>
<tr>
<td>Appearance</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</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>
<td>Y / N</td>
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<td>Pupils</td>
<td>Equal / Unequal</td>
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<tr>
<td>Hearing</td>
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<td>Cardiovascular</td>
<td>Y / N</td>
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<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
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<td>PMI location</td>
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<tr>
<td>Pulses (simultaneous femoral &amp; radial)</td>
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<td>Lungs</td>
<td>Y / N</td>
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<td>Abdomen</td>
<td>Y / N</td>
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<td>Genitourinary (Male)</td>
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<td>Hernia</td>
<td>Y / N</td>
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<td>Tanner Staging (optional)</td>
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<td>Skin (HSV, MRSA, Tinea corporis)</td>
<td>Y / N</td>
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<td>Neck</td>
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<td>Shoulder/Arm</td>
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<td>Foot/Toes</td>
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<tr>
<td>Functional (Duck Walk/Single Leg Hop)</td>
<td>Y / N</td>
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* Required Only if Multiple Examiners

Assessment: ☐ Cleared for sports without restriction ☐ Restricted participation (see Clearance Form)

Plan: Immunizations: ☐ Up-to-Date ☐ Immunize if needed (Required by age 12: DTaP series plus Td with Pertusis (Tdap), 4 Hib, 2 MMR, 3 HBV, 4 IPV, 2 varicella) ☐ Consider Flu Shot (Asthma, winter athletes) Health Maintenance: ☐ Lifestyle, health, and safety counseling ☐ Discussed dental care and mouthguard use ☐ Discussed Lead and TB exposure – (Testing indicated / not indicated)

Attending Physician Signature: __________________________________________ Date: _______________
Minnesota State High School League

2013-2014 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 and/or Physicians Assistant.)*

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 ______________________________________________________