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: __________________________ Address: __________________________
Office Telephone: _____ - _____ - _______ 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]

# 2017-2018 SPORTS QUALIFYING PHYSICAL HISTORY FORM

**Minnesota State High School League**

## Student Name: ____________________________  Birth Date: ________________  Date of Exam: ________________

### Circle Question Number(1) of questions for which the answer is unknown.  Circle Y for Yes or N for No

#### 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 or do you have any of the following medical condition(s) (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

#### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

7. Have you ever passed out or nearly passed out DURING exercise? Y / N
8. Have you ever passed out or nearly passed out AFTER 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? Y / N
   - High blood pressure  A heart murmur  High cholesterol  A heart infection  Rheumatic fever  Kawasaki’s Disease
12. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Y / N
13. Do you or someone in your family have sickle cell trait or disease? Y / N
14. Have you ever had a head injury or concussion? Y / N
15. Do you have groin pain or a painful bulge or swelling in your groin? Y / N
16. Does anyone in your family have a head problem, pacemaker, or implanted defibrillator? Y / N
17. Have you ever had an eating disorder? Y / N
18. Have you ever had an unexplained seizure? Y / N
19. Have you ever had a stress fracture? Y / N
20. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test) Y / N
21. Has anyone in your family who has asthma? Y / N
22. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise? Y / N
23. Have you or do you have anyone in your family with emphysema or chronic obstructive pulmonary disease? Y / N
24. Do you have these problems? Y / N
   - Asthma
   - Emphysema
   - Chronic obstructive pulmonary disease
25. Do you have any other problems with your heart? Y / N

#### MEDICAL QUESTIONS

26. 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
27. Have you had any broken or fractured bones or dislocated joints? Y / N
28. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Y / N
29. Have you ever had a stress fracture? Y / N
30. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Y / N
31. Do you have or do you have anyone in your family with arthritis? Y / N
32. Do you have or do you have anyone in your family with cancer? Y / N
33. Do you have or do you have anyone in your family with diabetes? Y / N
34. Do you have or do you have anyone in your family with epilepsy? Y / N
35. Do you have or do you have anyone in your family with heart disease? Y / N
36. Do you have or do you have anyone in your family with high blood pressure? Y / N
37. Do you have or do you have anyone in your family with hypertension? Y / N
38. Do you have or do you have anyone in your family with hypothyroidism? Y / N
39. Do you have or do you have anyone in your family with obesity? Y / N
40. Do you have or do you have anyone in your family with sickle cell trait or disease? Y / N
41. Do you have or do you have anyone in your family with type 1 or type 2 diabetes? Y / N
42. Do you have or do you have anyone in your family with hypertension? Y / N
43. Do you have or do you have anyone in your family with heart disease? Y / N
44. Do you have or do you have anyone in your family with obesity? Y / N
45. Do you have or do you have anyone in your family with hypothyroidism? Y / N
46. Do you have or do you have anyone in your family with type 1 or type 2 diabetes? Y / N
47. Do you or anyone in your family have sickle cell trait or disease? Y / N
48. Have you or does anyone in your family have sickle cell disease? Y / N
49. Have you or does anyone in your family have sickle cell anemia? Y / N
50. Have you or does anyone in your family have sickle cell trait? Y / N
51. Have you or does anyone in your family have sickle cell disease? Y / N
52. Have you or does anyone in your family have sickle cell anemia? Y / N
53. Have you or does anyone in your family have sickle cell trait? 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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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, 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**

<table>
<thead>
<tr>
<th>Exam</th>
<th>Normal</th>
<th>Abnormal Notes</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>HEENT</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Y / N</td>
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</tr>
<tr>
<td>Fundoscopic</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td>Equal / Unequal</td>
<td></td>
<td></td>
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<tr>
<td>Hearing</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Murmurs (standing, supine, +/- Valsalva)</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>PMI location</td>
<td>Y / N</td>
<td></td>
<td></td>
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<tr>
<td>Pulses (simultaneous femoral &amp; radial)</td>
<td>Y / N</td>
<td></td>
<td></td>
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<tr>
<td>Lungs</td>
<td>Y / N</td>
<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>Tanner Staging (optional)</td>
<td>I II III IV V</td>
<td></td>
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<tr>
<td>Skin (No HSV, MRSA, Tinea corporis)</td>
<td>Y / N</td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
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<tr>
<td>Neck</td>
<td>Y / N</td>
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</tr>
<tr>
<td>Back</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/Arm</td>
<td>Y / N</td>
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<tr>
<td>Elbow/Forearm</td>
<td>Y / N</td>
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<tr>
<td>Wrist/Hand/Fingers</td>
<td>Y / N</td>
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<tr>
<td>Hip/Thigh</td>
<td>Y / N</td>
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<tr>
<td>Knee</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>Leg/Ankle</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>Foot/Toes</td>
<td>Y / N</td>
<td></td>
<td></td>
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<tr>
<td>Functional (Single Leg Hop or Squat, Box Drop)</td>
<td>Y / N</td>
<td></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)
- [ ] 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 __________________________________________________________