

MSHSL 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 One Box)

(1) **Participate in all school interscholastic activities without restrictions.**

(2) **Participate in any activity not crossed out below.**

Sport classification based on contact

Collision Contact Sports	Limited Contact Sports	Non-contact Sports
Basketball Diving Ice Hockey Wrestling Boys' Lacrosse Football Soccer Adapted Soccer	Baseball Field Events High Jump Pole Vault Gymnastics Softball Adapted Softball Cheerleading Adapted Floor Hockey Nordic Skiing Alpine Skiing Girls' Lacrosse Volleyball	Badminton Field Events Discus Shot Put Tennis Adapted Bowling Dance Team Golf Cross Country Running Swimming Track

Sport classification based on intensity and strenuousness

High Intensity High-to-Moderate Dynamic High-to-Moderate Static	High Intensity High-to-Moderate Dynamic Low Static	High Intensity Low Dynamic High-to-Moderate Static	Low Intensity Low Dynamic Low Static
Alpine Skiing Cross Country Running Distance Track Events Football Ice Hockey Nordic Skiing Sprint Track Events Wrestling	Badminton Baseball Dance Team Lacrosse (Boys and Girls) Soccer Softball Swimming Tennis Volleyball	Cheerleading Diving Field Events Gymnastics	Golf

(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 Telephone: _____ - _____ - _____

COPY THIS CLEARANCE FORM FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE 3-PAGE FORM IN THE STUDENTS MEDICAL RECORD.

Valid for 3 years from above date with a normal Annual Health Questionnaire. [Year 2 Normal] [Year 3 Normal]

IMMUNIZATIONS [tD (required by age 12 or entry to 7th grade); MMR (2 required); hep B (3 required); varicella (or history of disease); poliomyelitis; 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 _____ - _____ - _____

MSHSL SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette 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)

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
HEENT	Y / N		
Eyes	Y / N		
Fundoscopic	Y / N		
Pupils	Equal / Unequal		
Ears/Nose	Y / N		
Hearing	Y / N		
Throat	Y / N		
Dental	Y / N		
Lymph Nodes	Y / N		
Thyroid	Y / N		
Heart	Y / N		
Murmurs	Y / N		
Pulses	Y / N		
Lungs	Y / N		
Abdomen	Y / N		
Genitourinary (male)	Y / N		
Hernia	Y / N		
Tanner Staging (optional)	I II III IV V		
Skin	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/fingers	Y / N		
Hip/thigh	Y / N		
Knee	Y / N		
Leg/ankle	Y / N		
Foot/Toes	Y / N		
Duck Walk	Y / N		

* Required Only if Multiple Examiners

Notes: _____

Assessment:

Immunizations: Up-to-Date

Health maintenance:

Plan:

Immunize if needed (Required by age 12 or entry to 7th grade: DTaP series plus tD with Pertusis, 4 HIB, 2 MMR, 3 HBV, 4 IPV)
 Consider flu Shot (Asthma, winter athletes)
 Lifestyle, health, and safety counseling
 Discussed dental care and mouthguard use
 Discussed Lead and TB exposure – (Testing indicated / not indicated)

2008-2009 MSHSL SPORTS QUALIFYING PHYSICAL HISTORY FORM
DATE OF EXAM _____

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Address: _____

Home Telephone: _____ - _____ - _____

School: _____ Grade: _____ Sports: _____

History

Circle Y for Yes or N for No

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

- 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 an ongoing medical condition (like diabetes or asthma)? 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 passed out or nearly passed out DURING exercise? Y / N
 - 6. Have you ever passed out or nearly passed out AFTER exercise? Y / N
 - 7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y / N
 - 8. Does your heart race or skip beats during exercise? Y / N
 - 9. Has a doctor ever told you that you have? (circle): High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever
 - 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram, stress test) Y / N
 - 11. Has anyone in your family died suddenly and unexpectedly for no apparent reason? Y / N
 - 12. Does anyone in your family have a heart problem? Y / N
 - 13. Has any family member or relative died of heart problems or sudden death before age 50? Y / N
 - 14. Has anyone in your family less than 50 years old had unexplained drowning while swimming or an unexplained car accident? Y / N
 - 15. Does anyone in your family have Marfan syndrome? Y / N
 - 16. Have you ever spent the night in a hospital Y / N
 - 17. Have you ever had surgery? Y / N
 - 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? Y / N
 - 19. Have you had any broken or fractured bones, or dislocated joints? Y / N
 - 20. Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y / N
- If Yes in Question 18, 19, 20, please circle the area below:**
- | | Head | Neck | Shoulder | Chest | Upper Arm | Elbow | Forearm | Hand/Fingers | Upper Back | Lower Back | Hip | Thigh | Knee | Calf/Shin | Ankle | Foot/Toes |
|--|------|------|----------|-------|-----------|-------|---------|--------------|------------|------------|-----|-------|------|-----------|-------|-----------|
|--|------|------|----------|-------|-----------|-------|---------|--------------|------------|------------|-----|-------|------|-----------|-------|-----------|
- FEMALES ONLY**
- 50. Have you ever had a menstrual period? Y / N
 - 51. How old were you when you had your first menstrual period? _____
 - 52. How many menstrual periods have you had in the last year? _____

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 _____

