Other Tests (optional)

_____ *Auditory*	_____ *U/A*	_____ *EKG*
_____ *% Body Fat*	_____ *Drug Screen*	_____ *Chest X-Ray*
_____ *Hgb/Hct*	_____ *SMAC*	_____ *Marfan Screen*

Assessment

1. *Clearance without limitation?* *Sports* _____

2. *Clearance deferred* *Reason* _____

3. *Clearance with limitation?* *Limitation* _____

4. *Disqualification* *Reason* _____

Examination Date _____ *Physician's Signature* _____

Additional Comments:

IHSA

Illinois High School Association

STUDENT'S NAME _____

SCHOOL NAME _____

IHSA Preparticipation Examination

To be completed by athlete or parent

Name _____ Sport/Position _____
Last First Middle

Social Security Number _____

School Year _____
Address _____
City/State _____ Phone No. _____
Birthdate _____ Age _____ Class _____ Student ID No. _____
Parent's Name _____
Address _____
Phone No. _____
Person to contact in case of emergency _____
Phone No. _____
Family Doctor _____ City/State _____
Phone No. _____

Past Medical History

		Yes	No	If yes, please explain (what, where, when)
1.	Presently taking medication (including birth control pills)			
2.	Allergic to medicine, foods, bee stings?			
3.	Wears any appliances—glasses, contact lenses?			
4.	History of braces, chipped teeth, bridges?			
5.	Has ongoing medical problem?			
6.	Had serious or significant illness in past?			
7.	Any past surgical operations, accidents, non-sports or related injuries?			
8.	Any past injuries directly related to sports?			
9.	Any hospitalization not explained above?			
10.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?			
11.	Any serious family illness (such as diabetes, bleeding disorders, heart attack before age 50, etc.)?			
12.	Any fainting or dizziness while exercising?			
13.	Any loss of consciousness, concussion, or head injury?			
14.	a. Last tetanus shot			Date _____
	b. Last dental examination			_____
	c. Last eye examination			_____
	d. Last menstrual period (if woman)			_____

Personal habits	Yes	No
1. Smoking		
2. Smokeless tobacco		
3. Alcohol		
4. Non-Medical drugs: marijuana, cocaine, etc.		
5. Steroids		
6. Eating disorders—weight loss or gain		

Review of systems (Please check if you have any problems with any of the following areas of your body)

_____ Skin
_____ Head
_____ Eyes
_____ Ears
_____ Nose
_____ Mouth/Throat
_____ Nutrition, Weight Control
_____ Neck
_____ Lungs
_____ Heart
_____ Abdomen
_____ Back
_____ Urination, Bowel Control
_____ Genital (including menstrual for women)
_____ Shoulders, Arms, Hands
_____ Hips, Legs, Feet
_____ Muscles—Strength, Feeling
_____ Mental, Emotional
_____ Fatigue
_____ Other: What?
_____

I certify that the above information is correct to the best of my knowledge.

Student Signature _____

Parent/Guardian Signature _____

Both Student And Parent/Guardian Signatures Are Mandatory

Physical Examination

Height _____ Weight _____ Blood Pressure _____
Pulse: resting _____ 15 hops _____ after 2 minutes _____
Visual Acuity: Eyes (R) 20/_____ w/o glasses _____ (L) 20/_____ w/ glasses _____

Other Testing	Normal	Abnormal Findings
1. General		
2. Skin		
3. HEENT		
4. Teeth (Dental examination)		
5. Neck		
6. Lungs		
7. Heart		
8. Breasts		
9. Abdomen		
10. Genitalia (Hernia)		
Tanner Stage (optional)		
11. Back		
12. Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
13. Peripheral Pulses		
14. Neurologic		
15. Mental Status		