MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name ______________________ Male ☐ Female ☐ Grade ________ Date of Birth ________

Home Address ______________________ Phone Number ______________________

Parent's Name ______________________ Family Physician ______________________

Current School ______________________ Date ______________________

Student Signature ______________________

Explain "Yes" answers below. Circle questions to which you don't know the answer.

Question	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Are you taking medicine for ADHD?	☐	☐
5. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (circle all that apply): High blood pressure; A heart murmur; High cholesterol; A heart infection		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
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: If yes, circle affected area below:	☐	☐
19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

Question	Yes	No
21. Have you ever had a stress fracture?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you ever had a head injury or concussion?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any problems with your eyes or visions?	☐	☐
41. Do you wear glasses or contact lenses?	☐	☐
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43. Are you happy with your weight?	☐	☐
44. Are you trying to gain or lose weight?	☐	☐
45. Have anyone recommended you change your weight or eating habits?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
48. Have you ever had a menstrual period?	☐	☐
49. How old were you when you had your first menstrual period?	____	
50. How many periods have you had in the last year?	____	

Explain "Yes" answers here:

____

____

____

____

____

____

____

____

____

____

Allergies: ______________________________________

Immunizations: (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis, pneumococcal; meningococcal, varicella)

____

Date of last known tetanus shot: ______________________________________

PROVIDER'S PHYSICAL EXAMINATION FORM

Name ______________________________ **Date of Birth** ____________________

Height ____________ **Weight** ____________ **Pulse** ________ **BP: Left Arm**_____/_____ **Right Arm** _____/_____

Vision R 20/______ **L 20/**______ **Corrected: Y N** **Pupils: Equal** ______ **Unequal** ______

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: ____

CLEARANCE

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: ____________________

☐ Not cleared for ☐ All sports ☐ Certain sports ____________________ Reason: ____________

Recommendations: ____

Name of physician/medical provider [print or type] ____________________ Date ____________

Address ____________________________________ Phone ____________

Signature of physician/medical provider ____________________________

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian ____________ Signature of parent or guardian ____________

Date ____________ Address ____________ Insurance (Company name) ____________

Parent's Home Phone ____________ Parent's Work Phone ____________ Parent's Cell Phone ____________ Additional Phone (if any-specify) ____________

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Updated 3/10)

Student-Athlete & Parent/Legal Custodian Concussion Statement

Because of the passage of the Dylan Steiger's Protection of Youth Athletes Act, schools are required to distribute information sheets for the purpose of informing and educating student-athletes and their parents of the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury. Montana law requires that each year, before beginning practice for an organized activity, a student-athlete and the student-athlete's parent(s)/legal guardian(s) must be given an information sheet, and both parties must sign and return a form acknowledging receipt of the information to an official designated by the school or school district prior to the student-athletes participation during the designated school year. The law further states that a student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from play at the time of injury and may not return to play until the student-athlete has received a written clearance from a licensed health care provider.

Student-Athlete Name:____
This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodian Name(s):___________________________________
☐ We have read the *Student-Athlete & Parent/Legal Custodian Concussion Information Sheet.*
If true, please check box

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	*N/A*
	If I think a teammate has a concussion, I should tell my coach(es), parents, or licensed health care professional about the concussion.	*N/A*
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	*N/A*
	I will/my child will need written permission from a licensed health care professional to return to play or practice after a concussion.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion fact sheet.	

_______________________________________ ___________________
Signature of Student-Athlete Date

_______________________________________ ___________________
Signature of Parent/Legal Custodian Date

MONFORTON SCHOOL DISTRICT #27 ATHLETICS

ACKNOWLEDGEMENT OF RISKS.

WAIVER. My child, ____, has my permission to participate in the Monforton School District 27 School Athletics Program, including all practices and competitive events. My child is in good physical condition except as noted on the SCHOOL ATHLETICS PARTICIPATION FORM and SCHOOL ATHLETICS PHYSICAL FORM as submitted for the current season.
In consideration for Monforton School accepting his/her participation, we (I), hereby, for myself, my child, my heirs, executors, administrators and assigns, waive and release any and all rights and claims for damage as a result of my child's participation in this program against Monforton School District 27, its employees, trustees, coaches and assistants.

If the child lives with both parents, both parents shall sign this form; otherwise, the legal custodial parent or legal guardian shall sign this form.

I have read, understood and agree to the information given in the Sports Activities Handbook.

Signature ____ **Date** __________________
Parent/Legal Guardian

Signature____**Date**__________________
Athletes Signature

Home Phone__________________ **Email**_____________________________

VERIFICATION OF INSURANCE. ***Your child must have medical insurance to participate in Monforton School's School Athletics Program. Please attest to this by completing the following:***
Insurance Company ____ ***Policy #*** ___________________________________

I have attached the necessary Athletic Fee of $40.00 for the first sport, ($30.00 for a second sport and $20.00 if playing a third sport) by way of: Check Money Order Cash

If the Athletic fee is a hardship please call Mr. Strauch at 586-1557.

Please return this form to Monforton Middle School Front Office.