

To b	e completed by athlete or parent				
Vam		Middle	_ Sport	/Position _	
	Last First	ivildale			
Socia	al Security Number		Schoo	ol Year	
	ress				
	State		Phone	e No.	
	ndateAge				
	nt's Name		_	_	
	ress				
	ne No				
	on to contact in case of emergency				
	ne No				
	ily Doctor	City/State			
		City/State			
nor	ne No				
Pas	t Medical History		Yes	No	If yes, please explain (what where, when
1.	Presently taking medication				where, when
	(including birth control pills)?				
2.	Have you been diagnosed with asthma?				
3.	Have you been prescribed by a physician	to			
	use any asthma medication?				
4.	Do you have a current consent form to				
	self-administer the asthma medication on	1			
	file with your school?	_			
5.	Allergic to medicine, foods, bee stings?				
6.	Wears any appliances—glasses, contact le				
7.	History of braces, chipped teeth, bridges?	<b>'</b> —			
8.	Has ongoing medical problem?				
9.	Had serious or significant illness in past?	_			
10.	Any past surgical operations, accidents,				
	non-sports or related injuries?	_			
11. 12.	Any past injuries directly related to sports				
12. 13.	Any hospitalization not explained above?  Any known deformities (such as curvature)				
10.	back, heart problems, one kidney, blindne				
	one eye, one testicle, etc.)?	.33 111			
14.	Any serious family illness (such as diabete	 es.			
	bleeding disorders, etc.)?	,			
15.	Heart				
	Have you ever passed out during or after	exercise?			
	Have you ever been dizzy during or after exercise?				
	Have you ever had chest pain during or				
	after exercise?				
	Do you get tired more quickly than your				
	friends do during exercise?	_			
	Have you ever had racing of your heart or				
	skipped heartbeats?				

		Yes	No	If yes, pleas explain (who where, whe
Have you had high blood pr	essure or			•
high cholesterol?				
Have you ever been told you	ı have a heart murmur?			
Has any family member or i	elative died of heart			
problems or of sudden deat	h before age 50?			
Have you had a severe viral	infection (for example			
myocarditis or mononucleos	sis) within the last month	h?		
Has a physician ever denied	or restricted your			
participation in sports for a	ny heart problems?			
Has anyone in your family h	ad a heart attack			
before the age of 50?				
Head and Nerve				
Have you ever had a head in	ijury or concussion?			
Have you ever been knocke	d out, become			
unconscious, or lost your m	emory?			
Have you ever had a seizure	?			
Do you have frequent or set	rere headaches?			
Have you ever had numbnes	ss or tingling in			
your arms, hands, legs or fe	et?			
Have you ever had a stinger	, burner or			
pinched nerve?				
Last tetnus shot?		Date		
Last eye exam?		Date		
Last menstrual period (if wo	omen)	Date		
onal Habits		Yes	No	
Smoking/smokeless tobacc	)			
Alcohol/non-medical drugs:	marijuana, cocaine, etc			
Steroids				
Eating Disorders - weight lo	ss or gain?			
w of systems (Please check	f you have any problems	with any o	f the followi	ng areas of you
Skin	Lungs		Shoo	ulders, Arms,
Head	Heart		Han	ds
Eyes	Abdomen		Hips	, Legs, Feet
Ears	Back		Mus	cles—Strength
Nose	Urination.		Feel	ina
Mouth/Throat	Bowel Control			tal, Emotional
Nutrition,	Genital (includin		Fatig	-
Weight Control menstrual f		_		er: What?
weight Control	mensuuai ioi w	onienj	Oure	:i. Wilat:
	Has any family member or r problems or of sudden deat Have you had a severe viral myocarditis or mononucleos Has a physician ever denied participation in sports for at Has anyone in your family h before the age of 50? Head and Nerve Have you ever had a head in Have you ever had a seizure Unconscious, or lost your m Have you ever had a seizure Do you have frequent or see Have you ever had a stinger your arms, hands, legs or fee Have you ever had a stinger pinched nerve? Last tetnus shot? Last eye exam? Last menstrual period (if wo Conal Habits Smoking/smokeless tobacce Alcohol/non-medical drugs: Steroids Eating Disorders – weight low of systems (Please check in Skin Head Eyes Ears Nose	Has any family member or relative died of heart problems or of sudden death before age 50?  Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month Has a physician ever denied or restricted your participation in sports for any heart problems?  Has anyone in your family had a heart attack before the age of 50?  Head and Nerve  Have you ever had a head injury or concussion?  Have you ever been knocked out, become unconscious, or lost your memory?  Have you ever had a seizure?  Do you have frequent or severe headaches?  Have you ever had numbness or tingling in your arms, hands, legs or feet?  Have you ever had a stinger, burner or pinched nerve?  Last tetnus shot?  Last eye exam?  Last menstrual period (if women)  **Conal Habits**  Smoking/smokeless tobacco  Alcohol/non-medical drugs: marijuana, cocaine, etc.  Steroids  Eating Disorders – weight loss or gain?  w of systems (Please check if you have any problems)  Skin	problems or of sudden death before age 50?  Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?  Has a physician ever denied or restricted your participation in sports for any heart problems?  Has anyone in your family had a heart attack before the age of 50?  Head and Nerve  Have you ever had a head injury or concussion?  Have you ever been knocked out, become unconscious, or lost your memory?  Have you ever had a seizure?  Do you have frequent or severe headaches?  Have you ever had numbness or tingling in your arms, hands, legs or feet?  Have you ever had a stinger, burner or pinched nerve?  Last tetnus shot?  Last eye exam?  Last menstrual period (if women)  Date  Sonoli Habits  Smoking/smokeless tobacco  Alcohol/non-medical drugs: marijuana, cocaine, etc  Steroids  Eating Disorders - weight loss or gain?  w of systems (Please check if you have any problems with any or systems (Please check if you have any problems with any or Ears  Back  Nose  Urination,	Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems? Has anyone in your family had a heart attack before the age of 50? Head and Nerve Have you ever had a head injury or concussion? Have you ever heen knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve? Last tetnus shot? Last eye exam? Last menstrual period (if women) Date  Sonal Habits Yes No Smoking/smokeless tobacco Alcohol/non-medical drugs: marijuana, cocaine, etc Steroids Eating Disorders - weight loss or gain?  w of systems (Please check if you have any problems with any of the following the dead heart Hanten

**Both Student And Parent/Guardian Signatures Are Mandatory** 

Phy:	sical Examination			
Height		Weight	Bloo	d Pressure
-		15 hops	after 2 minutes	
Visua	I Acuity: Eyes (R) 20/_	w/o glasses	(L) 20/	w/ glasses
Other	r Testing	Normal	Abnor	mal Findings
1.	General			
2.	Skin			
3.	HEENT			
4.	Teeth (Dental Exam)			
5.	Neck			
6.	Lungs			
7.	Heart (Sit and Stand)			
8.	Abdomen			
9.	Genitalia			
10.	Musculoskeletal			
	Neck			
	Shoulder/Arm			
	Elbow/Forearm			
	Wrist/Hand			
	Back			
	Hip/Thigh			
	Knee			
	Shin/Calf			
	Ankle/Leg			
	Foot			
11.	Peripheral Pulses			
12.	Neurologic			
13.	Mental Status			
14.	Marfan Screen			
	Tests (optional)			=1/2
	Auditory	U/V		EKG
	% Body Fat	Drug Scre		Chest X-Ray
	Hgb/Hct	SMAC		Tanner Stage
		on on this day, I appro	ve this child's parti	icipation in interscholastic
•	s for one year.			
Yes_	No	Lim	ited	
Addit	ional Comments:			
Exam	ination Date	Physicians Signat	ture	
	Physic	ian's Assistant Signatu	ıre*	
	Advanced Nur	se Practitioner Signatu	ıre*	

STUDENT'S NAME	
SCHOOL NAME	



## **Consent Form to self administer asthma medication**

(not needed if current form is already on file with school)

Parent Consent	
I,, do hereby go	ive my son/daughter,,
	medication as prescribed by his/her physician durin
Parent Signature	Date
Physician Consent	
As a patient under my care,	, is prescribed to self-administer the
following asthma medication.	
Medication	
Dosage	
Time/Special Circumstances	
Physician Signature	 Date

<sup>\*</sup> effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.