HIGH SCHOOL ACTIVITIES ASSOCIATION
IDAHO HEALTH EXAMINATION AND CONSENT FORM

All students are required complete a History and Physical examination prior to their first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the principal prior to the first practice.

Name _____ Home Address _____ Phone _____

Grade _____ Sports _____

Personal Physician _____ Physician's phone number _____

Date of Birth _____ Sex _____ School _____

HEALTH HISTORY

*Fill in details of "YES" answers in space below:

	YES	NO
1. A. Have you ever been hospitalized?	___	___
B. Have you ever had surgery?	___	___
2. Are you presently taking any medication or pills?	___	___
3. Do you have any allergies (medicine, bees, other stinging insects)?	___	___
4. A. Have you ever passed out during or after exercise?	___	___
B. Have you ever been dizzy during or after exercise?	___	___
C. Have you ever had chest pain during or after exercise?	___	___
D. Do you tire more quickly than your friends during exercise?	___	___
E. Have you ever had high blood pressure?	___	___
F. Have you ever been told you have a heart murmur?	___	___
G. Have you ever had racing of your heart or skipped beats?	___	___
H. Has anyone in your family died of heart problems or a sudden death before age 50?	___	___
5. Do you have any skin problems? (itching, rash, acne)	___	___
6. A. Have you ever had a head injury?	___	___
B. Have you ever been knocked out or unconscious?	___	___
C. Have you ever had a seizure?	___	___
D. Have you ever had a stinger, burner, or pinched nerve?	___	___
7. A. Have you ever had heat cramps?	___	___
B. Have you ever been dizzy or passed out in the heat?	___	___
8. Do you have trouble breathing or cough during or after exercise?	___	___
9. Do you use special equipment, pads, braces, mouth or eyeguards?	___	___
10. A. Have you had problems with your eyes or vision?	___	___
B. Do you wear glasses, contacts or protective eyewear?	___	___

11. Have you ever sprained/strained, dislocated, fractured/broken, or had repeated swelling or other injuries of any of your bones or joints?

___ Head ___ Neck ___ Chest ___ Back ___ Hip
___ Shoulder ___ Elbow ___ Forearm ___ Wrist ___ Hand
___ Thigh ___ Knee ___ Shin/Calf ___ Ankle ___ Foot

12. Have you ever had any other medical problems such as:

___ Mononucleosis ___ Diabetes ___ Asthma ___ Hepatitis ___ Headaches (frequent)
___ Tuberculosis ___ Eye injuries ___ Stomach ulcer ___ Other

13. Have you had a medical problem or injury since last exam? _____

14. When was your last tetanus shot? _____ When was your last measles immunization? _____

15. When was your first menstrual period? _____ When was your last menstrual period? _____
What was the longest time between periods last year? _____

*Explain "YES" answers here: _____

CONSENT FORM

(Parent or Guardian and Student Permission and Approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation. In the absence of parents, I also consent to the release of any information contained in this form to carry out treatment and health care operations for the above named student.

PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

SIGNATURE OF STUDENT _____ DATE: _____

PHYSICAL EXAMINATION FORM

Height _____ Weight _____ BP _____ / _____ Pulse _____ R _____

Visual acuity R 20/_____ L 20/_____ Corrected Y N Pupils _____

	Normal	Abnormal
Ears, Nose, Throat	_____	_____
Cardiopulmonary		
Pulses	_____	_____
Heart	_____	_____
Lungs	_____	_____
Skin	_____	_____
Abdominal	_____	_____
Genitalia	_____	_____
Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____

CLEARANCE / RECOMMENDATIONS

Clearance:

_____ A. Cleared for all sports and other school-sponsored activities.

_____ B. Cleared after completing evaluation / rehabilitation for: _____

_____ C. NOT cleared to participate in the following IHSAA sponsored sports:

Baseball	Cross Country	Golf	Tennis	Volleyball
Basketball	Football	Softball	Track	Wrestling

Not cleared for other school-sponsored activities:

(Example) 1 Soccer 2 Swimming 3 _____ 4 _____

_____ D. Student is NOT permitted to participate in high school athletics. Reason: _____

Recommendation: _____

Examiner's Signature: _____ Date: _____

(This Physical form must be signed by a licensed physician, physician's assistant or nurse practitioner)

Address: _____ Phone: _____