**O.K. Conference**
**Pre-Participation Physical Exam Form**

## Medical Examination

**THIS SIDE TO BE COMPLETED BY EXAMINING MEDICAL PROFESSIONAL**

| **Name**: | **Date**: | |
|---|---|---|

**Ht**:_____ **Wt**:_____ **HR**:_____ **BP**:_____ **BP reck**:_____
**Corrective Lenses**: Y or N **Vision**: R_____ L_____

| Physical Exam | Normal | Abnormal |
|---|---|---|
| General Appearance | | |
| HEENT | | |
| Lymph Nodes | | |
| Heart | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Skin | | |
| Neurologic | | |
| Spine | | |
| Upper Extremity | | |
| Lower Extremity | | |
| Joint Specific (optional) | | |
| Hernia (males only) | | |

COMMENTS

| General Medical | Musculoskeletal |
|---|---|
| | |
| | |

**RECOMMENDATIONS:**
1. [ ] CLEARED WITHOUT RESTRICTIONS
2. [ ] Cleared for LIMITED PARTICIPATION (specify)_____
_____
3. [ ] NOT CLEARED for participation (explanation) _____
_____
4. [ ] Requires further evaluation before final recommendation _____
_____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above.
**Printed Name:**_____ **Date:**_____
**Signature:**_____ **MD, DO, PA, or NP**

**A Current-Year Physical is one given on or after April 15 of the previous school year.**

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## Emergency Information

School: _____

Name:_____ DOB:_____ Gender: M F Grade:_____

Parent/Legal Guardian Name(s):_____

Address:_____
Street City State Zip

Phone #s: Home:_____ Work:_____ Cell:_____

**Emergency Contact(s):**

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

**Insurance Information:**

Family Insurance Co.:_____ Phone:_____

Contract/Group #:_____ Policy #:_____

**Parent/Legal Guardian Consent & Assumption of Risk:**

Participation in interscholastic athletics requires an acceptance of risk of injury. These risks include, but are not limited to the following: death, quadriplegia, paraplegia, internal injury, closed head injury (possibly including post-concussion syndrome) and musculo-skeletal injuries (including sprains, strains, and fractures). Some of these injuries may result in medical treatment, surgery, and/or permanent disability. I understand that coaches, athletic trainers, and physicians (including side-line team physicians) will use their professional judgment when administering proper medical treatment. I have had the opportunity to ask questions, hereby recognize the risk of injury, and give my consent for my son/daughter to participate in interscholastic athletics. I further consent for the disclosure of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics to the MHSAA, OK Conference, and school district. I also agree to accept and comply with all MHSAA, OK Conference, and school district athletic policies.

Parent/Legal Guardian Signature:_____ Date:_____

Student-Athlete Signature:_____Date:_____

**Authorization of Treatment:**

I, _____, hereby give my permission for my son/daughter, _____, to undergo medical treatment for any injury or illness he/she may sustain or acquire while participating in interscholastic athletics. I understand that medical personnel, including athletic trainers and sideline team physicians, will perform only those procedures within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries or illnesses. In the event more serious medical treatment/procedures are required and I cannot be reached for my consent, I authorize any licensed medical practitioner to perform such treatments/procedures medically necessary to alleviate the problem.

Parent/Legal Guardian Signature:_____ Date:_____

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## Medical History

1. Do you have any chronic or ongoing medical conditions? Yes No
   If yes, explain:_____
2. Have you ever been hospitalized and/or had surgery for any reason? Yes No
   If yes, explain:_____
3. Do you have any allergies (medications, insects, foods, etc.)? Yes No
   If yes, explan:_____
4. Are you currently taking any medications or supplements (include over-the-counter)? Yes No
   If yes, explain:_____
5. Have you had a medical problem or injury since your last physical exam? Yes No
   If yes, explain;_____
6. Have you ever passed out or nearly passed out during or after exercise? Yes No
   Have you ever had chest pain, tightness, or pressure during or after exercise? Yes No
   Have you ever been dizzy or light headed during or after exercise? Yes No
   Do you get more tired or short of breath than others during exercise? Yes No
   Does your heart ever race or skip beats (irregular beats) during exercise? Yes No
   Has a doctor ever ordered a test for your heart (e.g. ECG/EKG, echocardiogram? Yes No
   Have you ever been told you have any of the following (check all that apply):
   ☐High blood pressure ☐Heart murmur ☐High cholesterol
   ☐A heart infection ☐Kawasaki disease ☐Other:_____
   Explain ALL yes answers & checked items:_____
   _____
7. Has anyone in your family died suddenly ***or*** of heart problems before age 50? Yes No
   Do anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No
   Has anyone in your family had unexplained fainting, seizures, or near drowning? Yes No
   Does anyone in your family have any of the following cardiovascular conditions:
   ☐Hypertrophic cardiomyopathy ☐Marfan syndrome ☐Brugada syndrome
   ☐Arrythmogenic right ventricular cardiomyopathy ☐Long QT syndrome
   ☐Catecholaminergic polymorphic ventricular tachycardia ☐Short QT syndrome
   Explain ALL yes answers & checked items:_____
   _____
8. Have you ever had a concussion, head injury, or recurrent headaches? Yes No
   If yes, explain:_____
   Have you ever been knocked out or unconscious? Yes No
   If yes, explain:_____
   Do you have headaches with exercise? Yes No
   If yes, explain:_____
   Have you ever had any of the following after a hit, blow to the head, or falling:
   ☐Confusion ☐Prolonged headache ☐Inability to move your arms or legs
   ☐Memory problems ☐Numbness, tingling, or weakness in your arms or legs
   Explain ALL checked items (include dates):_____
   _____
   Have you ever had a stinger, burner, or pinched nerve? Yes No
   If yes, explain:_____
   Have you ever had seizures, convulsions, or a history of epilepsy? Yes No
   If yes, explain:_____
9. Have you ever become ill, dizzy, or passed out while exercising in the heat? Yes No
   If yes, explain:_____
   Do you get frequent muscle or heat cramps when exercising? Yes No
   If yes, explain:_____
   Do you or someone in your family have sickle cell trait or disease? Yes No
   If yes, explain:_____
10. Do you or someone in your family have asthma or another obstructive lung disorder? Yes No
    If yes, explain:_____
    Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
    If yes, explain:_____
    Have you ever used an inhaler or taken asthma medication? Yes No
    If yes, explain:_____
11. Do you currently have, or have you EVER HAD any of the following:
    ☐Hernia ☐Mononucleosis ☐Diabetes ☐Kidney disease ☐Scoliosis ☐Absent spleen
    Explain ALL checked items (include dates):_____
    _____
12. Are you missing one of a set of paired organs (kidneys, eyes, ovaries, testes, etc.)? Yes No
    If yes, explain:_____
13. Have you ever sprained, strained, dislocated, fractured, broken, experienced repeated swelling in, had a stress fracture in, or otherwise injured any bones or joints? (check all that apply)
    ☐Head ☐Neck ☐Chest/ribs ☐Back ☐Shoulder ☐Forearm ☐Elbow ☐Wrist
    ☐Hip ☐Thigh ☐Calf/shin ☐Knee ☐Ankle ☐Foot/toes ☐Hand/fingers
    Explain ALL checked answers (include dates):_____
    _____
    _____
14. Have you ever had a condition/injury that required x-rays, MRI, CT scan, or therapy? Yes No
    If yes, explain:_____
15. Do you use any special equipment (braces, pads, mouthguards, neck rolls, etc.)? Yes No
    If yes, explain:_____
16. Have you had any problems with your vision or injuries to your eyes? Yes No
    Do you wear glasses, corrective lenses, or protective eyewear? Yes No
    Explain ALL yes answers:_____
17. Have you ever had any skin problems (rashes, itching, MRSA, herpes, acne)? Yes No
    If yes, explain:_____
18. Have you ever had an eating disorder or restricted food to lose weight? Yes No
    Do you want to weigh MORE or LESS than you do now? Yes No
    Do you feel stressed? Yes No
    Explain ALL yes answers:_____
20. **FEMALES ONLY** Age at 1st menstrual period?_____ Date of most recent?_____
    Number of periods in the last 12 months?_____ Longest time between periods?_____
21. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
    If yes, explain;_____

****I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.**

Signature of Athlete:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____