

COPY this Clearance Form for the student to return to the school. KEEP the complete document in the student's medical record.

SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM
Minnesota State High School League

Student Name: Birth Date: Age: Gender: M / F
Address:
Home Telephone: Mobile Telephone
School: Grade: Sports:

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check Only One Box)

- (1) Participate in all school interscholastic activities without restrictions.
(2) Participate in any activity not crossed out below.

Table with 3 columns: Collision Contact Sports, Limited Contact Sports, Non-contact Sports. Lists various sports like Basketball, Baseball, Badminton, etc.

Table with 3 columns: A. Low (<40% Max O2), B. Moderate (40-70% Max O2), C. High (>70% Max O2). Rows represent increasing static component (I, II, III) and increasing dynamic component (A, B, C).

- (3) Requires further evaluation before a final recommendation can be made. Additional recommendations for the school or parents:

- (4) Not cleared for: All Sports, Specific Sports
Reason:

Sport Classification Based on Intensity & Strenuousness: This classification is based on peak static and dynamic components achieved during competition. It should be noted, however, that higher values may be reached during training.

I have examined the above named student and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents.

Attending Physician Signature Date of Exam
Print Physician Name:
Office/Clinic Name Address:
City, State, Zip Code
Office Telephone: E-Mail Address:

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 1-2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual)]
Up-to-date (see attached school documentation) Not up-to-date / Specify
IMMUNIZATIONS GIVEN TODAY:

EMERGENCY INFORMATION
Allergies
Other Information
Emergency Contact: Relationship
Telephone: (H) (W) (C)
Personal Physician Office Telephone

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.
FOR SCHOOL ADMINISTRATION USE: [Year 2 Normal] [Year 3 Normal]
Reference: Preparticipation Physical Evaluation (4th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2010.

SPORTS QUALIFYING PHYSICAL HISTORY FORM
Minnesota State High School League

Student Name: _____ Birth Date: _____ Date of Exam: _____

History

Circle Question Number (1) of questions for which the answer is unknown. No

Circle Y for Yes or N for No

GENERAL QUESTIONS

- 1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? Y / N
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infections)? Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y / N
List: _____
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y / N
5. Have you ever spent the night in a hospital? Y / N
6. Have you ever had surgery? Y / N

HEART HEALTH QUESTIONS ABOUT YOU

- 7. Have you ever passed out or nearly passed out DURING exercise? Y / N
8. Have you ever passed out or nearly passed out AFTER exercise? Y / N
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y / N
10. Does your heart race or skip beats (irregular beats) during exercise? Y / N
11. Has a doctor ever told you that you have? (circle):
High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever Kawasaki's Disease
12. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test) Y / N
13. Do you get lightheaded or feel more short of breath than expected during exercise? Y / N
14. Have you ever had an unexplained seizure? Y / N
15. Do you get more tired or short of breath more quickly than your friends during exercise? Y / N

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

- 16. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning, unexplained car accident, or sudden infant death syndrome)? Y / N
17. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Y / N
18. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Y / N
19. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Y / N

BONE AND JOINT QUESTIONS

- 20. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? Y / N
21. Have you had any broken or fractured bones or dislocated joints? Y / N
22. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Y / N
23. Have you ever had a stress fracture? Y / N
24. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Y / N
25. Do you regularly use a brace, orthotics or other assistive device? Y / N
26. Do you have a bone, muscle, or joint injury that bothers you? Y / N
27. Do any of your joints become painful, swollen, feel warm, or look red? Y / N
28. Do you have any history of juvenile arthritis or connective tissue disease? Y / N

MEDICAL QUESTIONS

- 29. Has a doctor ever told you that you have asthma or allergies? Y / N
30. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise? Y / N
31. Is there anyone in your family who has asthma? Y / N
32. Have you ever used an inhaler or taken asthma medicine? Y / N
33. Do you develop a rash or hives when you exercise? Y / N
34. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ? Y / N
35. Do you have groin pain or a painful bulge or hernia in the groin area? Y / N
36. Have you had infectious mononucleosis (mono) within the last month? Y / N
37. Do you have any rashes, pressure sores, or other skin problems? Y / N
38. Have you had a herpes or MRSA skin infection? Y / N
39. Have you ever had a head injury or concussion? Y / N
40. Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems? Y / N
41. Do you have a history of seizure disorder? Y / N
42. Do you have headaches with exercise? Y / N
43. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y / N
44. Have you ever been unable to move your arms or legs after being hit or falling? Y / N
45. Have you ever become ill while exercising in the heat? Y / N
46. Do you get frequent muscle cramps when exercising? Y / N
47. Do you or someone in your family have sickle cell trait or disease? Y / N
48. Have you had any problems with your eyes or vision? Y / N
49. Have you had any eye injuries? Y / N
50. Do you wear glasses or contact lenses? Y / N
51. Do you wear protective eyewear, such as goggles or a face shield? Y / N
52. Do you worry about your weight? Y / N
53. Are you trying to or has anyone recommended that you gain or lose weight? Y / N
54. Are you on a special diet or do you avoid certain types of foods? Y / N
55. Have you ever had an eating disorder? Y / N
56. Do you have any concerns that you would like to discuss with a doctor? Y / N

FEMALES ONLY

- 57. Have you ever had a menstrual period? Y / N
58. How old were you when you had your first menstrual period? _____
59. How many menstrual periods have you had in the last year? _____

Notes: _____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

Parent or Legal Guardian Signature

Student-Athlete Signature

Date

2015-2016 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

Minnesota State High School League

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette, cigar, or pipe smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had any alcohols, even just one?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
9. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____
 Pulse _____ BP _____ / _____ (_____ / _____)
 Vision: R 20/ _____ L 20/ _____ Corrected: Y / N Contacts: Y / N Hearing: R _____ L _____ (Audiogram or confrontation)

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
No Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	Y / N		
HEENT	Y / N		
Eyes	Y / N		
Fundoscopic	Y / N		
Pupils	Equal / Unequal		
Hearing	Y / N		
Cardiovascular	Y / N		
No Murmurs (standing, supine, +/- Valsalva)	Y / N		
PMI location			
Pulses (simultaneous femoral & radial)	Y / N		
Lungs	Y / N		
Abdomen	Y / N		
Tanner Staging (optional)	I II III IV V		
Skin (No HSV, MRSA, Tinea corporis)	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/Fingers	Y / N		
Hip/Thigh	Y / N		
Knee	Y / N		
Leg/Ankle	Y / N		
Foot/Toes	Y / N		
Functional (Single Leg Hop or Squat, Box Drop)	Y / N		

* Required Only if Multiple Examiners

Notes: _____

Assessment: Cleared for sports without restriction Restricted participation (see Clearance Form)
Plan: **Immunizations:** Up-to-Date Recommend Annual Flu Shot (Especially for Asthma & winter athletes) Consider HPV series
 Immunize if needed (Tdap, meningococcal MCV4, (1-2 doses), 3 HPV, 2 MMR, 3 hep B, 3-4 Polio, 2 varicella or history of disease)
Health Maintenance: Lifestyle, health, and safety counseling Discussed dental care and mouthguard use
 Discussed Lead and TB exposure – (Testing indicated / not indicated) Eye Refraction if indicated

Attending Physician Signature: _____ Date: _____

2015-2016 PI ADAPTED ATHLETICS PHYSICAL EXAM FORM Addendum

(Use only for Adapted Athletics - PI Division)

The MSHSL has competitive interscholastic Physically Impaired (PI) competition. Students who are deemed fit to participate in competitive athletics from a MSHSL sports qualifying exam should meet the criteria below to participate in Adapted Athletics – PI Division.

The MSHSL Adapted Athletics PI Division program is specifically intended for students with physical impairments who have medical clearance to compete in competitive athletics. A student is eligible to compete in the PI Division with one of the following criteria:

The student must have a diagnosed and documented impairment specified from one of the two sections below: *(Must be diagnosed and documented by a Physician Physician’s Assistant, and/or Advanced Practice Nurse.)*

- 1. _____ Neuromuscular _____ Postural/Skeletal _____ Traumatic
- _____ Growth _____ Neurological Impairment

Which: _____ affects Motor Function _____ modifies Gait Patterns

(Optional) _____ Requires the use of prosthesis or mobility device, including but not limited to canes, crutches, walker or wheelchair.

- 2. _____ Cardio/Respiratory Impairment that is deemed safe for competitive athletics, but limits the intensity and duration of physical exertion such that sustained activity for over five minutes at 60% of maximum heart rate for age results in physical distress in spite of appropriate management of the health condition.

(NOTE:) A condition that can be appropriately managed with appropriate medications that eliminate physical or health endurance limitations WILL NOT be considered eligible for adapted athletics.

Specific exclusions to PI competition:

The following health conditions, without coexisting physical impairments as outlined above, do not qualify the student to participate in the PI Division even though some of the conditions below may be considered Health Impairments by an individual’s physician, a student’s school, or government agency. This list is not all-inclusive and the conditions are examples of non-qualifying health conditions; other health conditions that are not listed below may also be non-qualifying for participation in the PI Division.

Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Emotional Behavioral Disorder (EBD), Autism spectrum disorders (including Asperger’s Syndrome), Tourette’s Syndrome, Neurofibromatosis, Asthma, Reactive Airway Disease (RAD), Bronchopulmonary Dysplasia (BPD), Blindness, Deafness, Obesity, Depression, Generalized Anxiety Disorder, Seizure Disorder, or other similar disorders.

Student Name _____

Attending Physician/Physician Assistant (PRINT) _____

Attending Physician/Physician Assistant (SIGNATURE) _____

Date of Physical Exam _____