FORM A

USE THIS FORM FOR INITIAL PHYSICAL EXAM

Instructions for use of pre-participation (athletic)
Health Examination and Consent Form

Instructions for completing FORM A

COMPLETING THIS FORM:

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian with the student are to complete the Health History on page 3 of Form A and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:

1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed and the Pre-participation Physical Evaluation (FORM A) must be completed before any student may participate in athletic activities sponsored by this Association. Clearance Form (Form B) must be completed by the parent each subsequent year. A re-evaluation physical examination will be required if any changes appear for questions 1-16 on the Health History form (Form B). Forms A and B along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on Health Examination Form A or B.

_____ _____

Name of Student *School*

Is the student covered by health/accident insurance? ☐Yes ☐No

_____

Name of health insurance provider

If no insurance provider, explain _____

_____

_____

_____

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. *http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf*

_____ _____

Parent or Guardian Name *Parent or Guardian Signature*

_____

Date

Student Statement

By signing below I acknowledge:

- 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 Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

_____ _____

Signature of Student *Date*

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

Pre-Participation Physical Evaluation

Health History

Date of Exam_____

Name_____ Age_____ Sex_____ Date of Birth_____

Grade_____ School_____ Sport(s)_____

Address_____ City_____ State_____ Phone_____

Personal Physician_____

In case of emergency, contact:

Name_____ Relationship_____ Phone(H)_____ Phone(W)_____

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

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
• Do you have an on-going or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
• Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	☐	☐
• Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
• Have you ever had a rash or hives develop during or after execise?	☐	☐
5. 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?	☐	☐
• Have you had high blood pressure or high cholesterol?	☐	☐
• Have you ever been told you have a heart murmur?	☐	☐
• 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?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
• Have you ever been knocked out, become unconcious, 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?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity	☐	☐
• Do you have asthma?	☐	☐
• Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. Do you have any special or corrective equipment or devices that aren't usually used for your sport or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid, etc.)	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
• Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
• Have you broken or fractured any bones or dislocated any joints?	☐	☐
• Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check appropriate box and explain below.

☐Head	☐Elbow	☐Hip
☐Neck	☐Forearm	☐Thigh
☐Chest	☐Wrist	☐Knee
☐Shoulder	☐Hand	☐Shin/calf
☐Upper Arm	☐Finger	☐Ankle
		☐Foot

13. Do you want to weigh more or less than you do now?	☐	☐
• Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period?_____
When was your most recent menstrual period?_____
How much time do you usually have from the start of one period to the start of another?_____
How many periods have you had in the last year?_____
What was the longest time between periods in the last year?_____

EXPLAIN ANY YES ANSWERS HERE

_____
_____
_____
_____
_____
_____

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

Signature of Student_____ Signature of Parent_____ Date_____

Pre-Participation Physical Evaluation

Physical Examination

Name_____ Date of Birth_____

Height_____ Weight_____ % Body Fat (Optional)_____ Pulse_____ BP_____/_____ (_____/_____)

Vision R 20/_____ L 20/_____ Corected Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Stabon-based examination only

CLEARANCE

☐Cleared

☐Cleared after completing evaluation/rehabilitation for:_____

_____

_____

☐Not cleared for:_____ Reason:_____

Recommendations: _____

_____

_____

_____

_____

Name of Physician (print/type)_____ Date_____

Address_____ Phone_____

Signature of physician_____ MD, DO,PAC,RNP,DC