WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year .

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Cleared without restriction** ❑ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

❑ **Not cleared for** ❑ **All sports** ❑ **Certain sports:** _____ **Reason:** _____

Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)* : _____ **OR APNP:** _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

***** Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

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WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

Student's Name _____

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____

Policy Numbers and Address _____

Emergency Information

Allergies _____

Other Information (medication,etc.) _____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** _____
(e.g., tetanus/diphtheria;measles, mumps, rubella;hepatitis A, B;influenza;poliomyelitis;pneumococcal;meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to:Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Preparticipation Physical Evaluation (Medical History to be Retained by Physician/Provider)

HISTORY FORM

DATE OF EXAM _____

Name (Last) _____ (First) _____ (Middle Initial) _____ Date of birth _____

Grade _____ Age _____ Sex _____ School _____ Sport(s) _____

City _____ State _____ Zip Code _____ Telephone _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Telephone (H) _____ (W) _____

Explain "Yes"answer(s) below. Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress facture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period? _____	☐	☐
49. How many periods have you had in the last 12 months? _____	☐	☐

Explain "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 athlete _____ Signature of parent/guardian _____ Date _____

Revised 6/05

Preparticipation Physical Evaluation
(Medical History to be Retained by Physician/Provider)

PHYSICAL EXAMINATION FORM

Name (Last)_____ (First) _____ (Middle Initial)_____ Date of birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse_____ BP_____ / _____ (_____ / _____ , _____ / _____)

Vision R 20 / _____ L 20 / _____ Corrected: Y N PUPILS: EQUAL_____ UNEQUAL_____

Follow-Up Questions on More Sensitive Issues

	Yes	No
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 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 at least 1 drink of alcohol?	☐	☐
7. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
9. Questions from the Youth Risk Behavior Survey (http://cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.	☐	☐

Notes:_____

_____

_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination

Notes:_____

_____

Name of physician or APNP (print/type) _____ Date:_____

Address _____ Telephone _____

Signature of physician: _____MD/DO or APNP: _____