

**DAVENPORT COMMUNITY SCHOOL DISTRICT
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION**

The certificate of physical examination is valid for the purpose of this rule for one calendar year. A grace period not to exceed thirty days is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please Print) SCHOOL _____

NAME _____ MALE _____ FEMALE _____ DATE OF BIRTH _____ GRADE _____

HOME ADDRESS _____ PHONE # _____

PARENT'S NAME _____ FAMILY PHYSICIAN _____

WORK # _____ EMERGENCY CONTACT # _____

EMERGENCY CONTACT PERSON _____

**HEALTH HISTORY (Student Athlete or Parent/Guardian to Fill Out #1 - 31 Before Exam)
(Parent/Guardian Required to Sign on Back of the Form After Examination.)**

- | Yes | No | Has This Student Had Any? | Yes | No | Has This Student Had Any? |
|-----------|-------|---|------------|-----------|---------------------------------------|
| 1. _____ | _____ | Chronic or recurrent illness? | 14. _____ | _____ | Asthma? |
| 2. _____ | _____ | Hospitalizations? | 15. _____ | _____ | Epilepsy? |
| 3. _____ | _____ | Surgery, other than tonsillectomy? | 16. _____ | _____ | Diabetes? |
| 4. _____ | _____ | Missing organs (eye, kidney, testicle)? | 17. _____ | _____ | Eyeglasses or contact lenses? |
| 5. _____ | _____ | Allergy to medications? | 18. _____ | _____ | Dental braces, bridges, plates? |
| 6. _____ | _____ | Problems with heart or blood pressure? | | | |
| 7. _____ | _____ | Chest pain with exercise? | Yes | No | Is there a history of? |
| 8. _____ | _____ | Dizziness or fainting with exercise? | 19. _____ | _____ | Injuries requiring medical treatment? |
| 9. _____ | _____ | Frequent headaches, convulsions, dizziness or fainting? | 20. _____ | _____ | Neck injury? |
| 10. _____ | _____ | Concussion or unconsciousness? | 21. _____ | _____ | Knee injury? |
| 11. _____ | _____ | Heat exhaustion, heat stroke, or other heat problems? | 22. _____ | _____ | Knee surgery? |
| 12. _____ | _____ | Any illness lasting over a week? | 23. _____ | _____ | Ankle injury? |
| 13. _____ | _____ | Rheumatic fever? | 24. _____ | _____ | Other serious joint injury? |
| | | | 25. _____ | _____ | Broken bones (fractures)? |

- Yes No Further History:**
26. _____ Is there any history of family or genetic disease?
27. _____ Has any family member died suddenly at less than 40 years of age of causes other than an accident?
28. _____ Has any family member had a heart attack at less than 55 years of age?
29. _____ Are you uncomfortably short of breath after running 1/2 mile (2 times around the track) without stopping?
30. List all medications you are presently taking and what condition the medication is for.

- A.
B.
C.

31. What is the most and the least you have weighed in the past year? **Most** _____ / **Least** _____

Date of last known tetanus (lockjaw) shot: _____

FOR WOMEN ONLY:

1. How old were you when you had your first menstrual period? _____
2. In the past year, what is the longest time you have gone between menstrual periods? _____

Use this space to **explain** any of the **above numbered YES answers** or to provide any additional information:

PHYSICAL EXAMINATION RECORD (To Be Filled Out by Licensed Professional)

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose and Throat			
3. Mouth and Teeth			
4. Neck			
5. Cardiovascular			
6. Chest and Lungs			
7. Abdomen			
8. Skin			
9. Musculoskeletal: ROM, strength, etc.			
10. Neurological			

Comments re Abnormal Findings: _____

Participation Recommendations

_____ Full and Unlimited Participation
 _____ Clearance Pending Documented Follow Up Of _____
 _____ No Athletic Participation Due To _____

 Licensed Professional's Name (Printed) _____ Date _____

 Signature _____ Phone _____

Parent's or Guardian's Permission and Release

I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to give first aid treatment to this student at an athletic event in case of injury.

 Typed or Printed Name of Parent or Guardian _____ Signature of Parent or Guardian _____

 Address _____ Phone _____ Date _____

INSURANCE NOTICE

The school district does **NOT** purchase an insurance policy for athletes. School time insurance is offered at a nominal fee and partially covers all sports **EXCEPT** football. Football players who purchase school time insurance may also purchase a policy for football at their own additional expense. It is agreed that the cost of any and all treatment for injury or injuries sustained by my son/daughter shall be the responsibility of the parent (guardians) and that all such costs will be paid by us, thus releasing the schools from all financial obligations. Participation in athletic competition may result in serious or fatal injuries.

CHECK ONE BOX We plan to participate in the insurance program offered by the school district, as outlined in the insurance letter available at registration in August. We are aware this insurance is not in effect until the form and payment have been received by the school.

We do **not** wish to participate in the school district insurance program, as we have our own insurance and/or will assume responsibility and costs for injuries.