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?
1.	_____	_____	Chronic or recurrent illness?
2.	_____	_____	Hospitalizations?
3.	_____	_____	Surgery, other than tonsillectomy?
4.	_____	_____	Missing organs (eye, kidney, testicle)?
5.	_____	_____	Allergy to medications?
6.	_____	_____	Problems with heart or blood pressure?
7.	_____	_____	Chest pain with exercise?
8.	_____	_____	Dizziness or fainting with exercise?
9.	_____	_____	Frequent headaches, convulsions, dizziness or fainting?
10.	_____	_____	Concussion or unconsciousness?
11.	_____	_____	Heat exhaustion, heat stroke, or other heat problems?
12.	_____	_____	Any illness lasting over a week?
13.	_____	_____	Rheumatic fever?

	Yes	No	Has This Student Had Any?
14.	_____	_____	Asthma?
15.	_____	_____	Epilepsy?
16.	_____	_____	Diabetes?
17.	_____	_____	Eyeglasses or contact lenses?
18.	_____	_____	Dental braces, bridges, plates?

	Yes	No	Is there a history of?
19.	_____	_____	Injuries requiring medical treatment?
20.	_____	_____	Neck injury?
21.	_____	_____	Knee injury?
22.	_____	_____	Knee surgery?
23.	_____	_____	Ankle injury?
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 <u>year</u>, 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.