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

2017-18 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.**

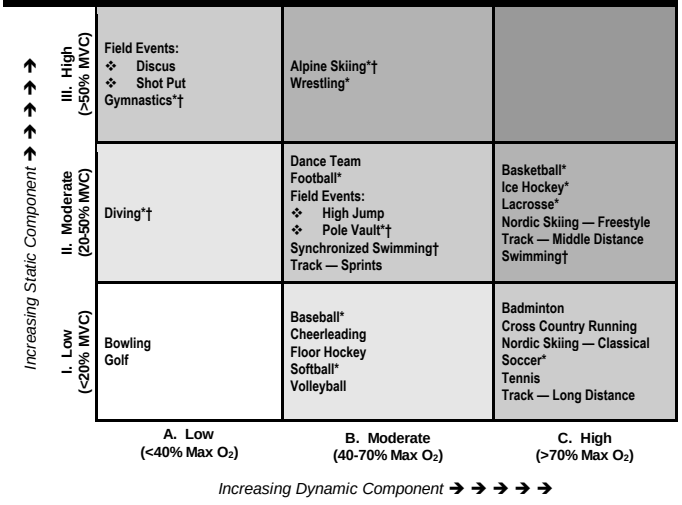
Sport Classification Based on Contact

Collision Contact Sports	Limited Contact Sports	Non-contact Sports
Basketball Cheerleading Diving Football Gymnastics Ice Hockey Lacrosse Alpine Skiing Soccer Wrestling	Baseball Field Events: ❖ High Jump ❖ Pole Vault Floor Hockey Nordic Skiing Softball Volleyball	Badminton Bowling Cross Country Running Dance Team Field Events: ❖ Discus ❖ Shot Put Golf Swimming Tennis Track

☐ **(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



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. The increasing dynamic component is defined in terms of the estimated percent of maximal oxygen uptake ($MaxO_2$) achieved and results in an increasing cardiac output. The increasing static component is related to the estimated percent of maximal voluntary contraction (MVC) reached and results in an increasing blood pressure load. The lowest total cardiovascular demands (cardiac output and blood pressure) are shown in lightest shading and the highest in darkest shading. The graduated shading in between depicts low moderate, moderate, and high moderate total cardiovascular demands. *Danger of bodily collision. †Increased risk if syncope occurs. Reprinted with permission from: Maron BJ, Zipes DP. 36th Bethesda Conference: eligibility recommendations for competitive athletes with cardiovascular abnormalities. *J Am Coll Cardiol.* 2005; 45(8):1317–1375.

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.

2017-18 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. 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

2017-18 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: _____