TO: PARENTS OF MHSA SPORTS PARTICIPANTS
LICENSED MEDICAL PROFESSIONALS

FROM: MARK BECKMAN, EXECUTIVE DIRECTOR

RE: NEW MHSA PRE-PARTICIPATION PHYSICAL EXAM FORM

Article II, Section (3) of the MHSA Handbook requires that a physical exam must be performed for each student in order for that student to be considered eligible for participation in an Association Contest. Physical exams must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year.

The MHSA Executive Board approved some important additions to this form several years ago. Specifically, questions concerning the cardiac history and cardiac health of the student have been added (questions 6-15). The MHSA Medical Advisory Committee strongly recommends that if any of those questions are answered affirmatively the student be referred to the appropriate medical professional for further screening. Also new this year is an updated section on vaccinations to be completed, which serves as a reminder to parents about the recommended vaccinations for their child. This addition was recommended by the State of Montana Health Department.

The MHSA pre-participation form is the only form that will be allowed for the student's exam (no other forms will be accepted). The following process should be followed:

- Parent(s)/Legal Guardian(s) and each student should fill out the questionnaire and history portion of the form together, which is the front page of the MHSA pre-participation physical examination form.
- The form goes to the medical provider for use during the examination.
- The medical provider reviews the form with the student and parent/guardian, performs the exam and makes the decision on whether to clear the student for participation. A signature from the medical provider is required.
- The student must sign this form confirming that he/she was involved in the completion process. **This signature was moved to the last page with other signatures.**
- The physical exam form is given to the parent/guardian. He/she must sign the permission and release section of the form for final clearance.
- The completed pre-participation physical exam form is given to the appropriate school administrator.

The MHSA is committed to the safety and health of our student activity participants and believes this new form will facilitate that objective.

If you have any questions regarding the new pre-participation examination form please contact me or Brian Michelotti, MHSA Assistant Director.
MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name ___________________________ Male □ Female □ Grade _______ Date of Birth _______
Home Address ___________________________ Phone Number _______
Parent’s Name ___________________________ Family Physician _______
Current School ___________________________ Date _______

Explain “Yes” answers below. Circle questions to which you don’t know the answer.

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

FEMALES ONLY
21. Have you ever had a menstrual period? □ Yes □ No
22. How old were you when you had your first menstrual period? ______
23. How many periods have you had in the last year? ______
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? □ Yes □ No
25. Do you cough, wheeze, or have difficulty breathing during or after exercise? □ Yes □ No
26. Has anyone recommended you change your weight or eating habits? □ Yes □ No
27. Are you trying to gain or lose weight? □ Yes □ No
28. Have you ever used an inhaler or taken asthma medicine? □ Yes □ No
29. Have you ever had an allergic reaction to any food? □ Yes □ No
30. Have you ever used an inhaler or taken asthma medicine? □ Yes □ No
31. Do you have any concerns that you would like to discuss with a doctor? □ Yes □ No
32. Have you ever had a head injury or concussion? □ Yes □ No
33. Have you been in a car accident or automobile accident? □ Yes □ No
34. Have you ever had a seizure? □ Yes □ No
35. Do you have headaches with exercise? □ Yes □ No
36. Do you take any prescription or nonprescription medicines or pills? □ Yes □ No
37. Have you ever been unable to move your arms or legs after being hit or falling? □ Yes □ No
38. When exercising in the heat, do you have severe muscle cramps or heat exhaustion? □ Yes □ No
39. Have you ever had a heart problem? □ Yes □ No
40. Have you ever had an allergic reaction to any insect sting? □ Yes □ No
41. Do you have a heart murmur? □ Yes □ No
42. Have you been in a car accident or automobile accident? □ Yes □ No
43. Are you happy with your weight? □ Yes □ No
44. Are you trying to gain or lose weight? □ Yes □ No
45. Have anyone recommended you change your weight or eating habits? □ Yes □ No
46. Do you or your family have any weight-related problems? □ Yes □ No
47. Do you have any concerns that you would like to discuss with a doctor? □ Yes □ No
48. Do you have any allergies to medicines, pollens, foods, or stinging insects? □ Yes □ No
49. Do you take any prescription or nonprescription medicines or pills? □ Yes □ No
50. How many periods have you had in the last year? ______

Allergies: ___________________________

Required for School* and Recommended Immunizations: (please check if student is up-to-date): □ Hepatitis A; □ Hepatitis B; □ Human Papillomavirus (HPV); □ Influenza; □ Measles, Mumps, Rubella (MMR)*; □ Meningococcal; □ Polio*; □ Tetanus/Diphtheria/Pertussis (Tdap)*; □ Varicella (Chickenpox)*

Date of last known tetanus shot (Tdap): ___________________________
### PROVIDER'S PHYSICAL EXAMINATION FORM

Name __________________________________________ Date of Birth ____________________

Height ____________ Weight ______________ Pulse __________ BP: Left Arm_______/_______ Right Arm _______/_______

Vision R 20/_______ L 20/_______ Corrected: Y N Pupils: Equal _______ Unequal _______

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**MUSCULOSKELETAL**

| Neck               |        |                   |           |
| Back               |        |                   |           |
| Shoulder/arm       |        |                   |           |
| Elbow/forearm      |        |                   |           |
| Wrist/hands/fingers|        |                   |           |
| Hip/thigh          |        |                   |           |
| Knee               |        |                   |           |
| Leg/ankle          |        |                   |           |
| Foot/toes          |        |                   |           |

*Multiple examiner set-up only.

Notes: ________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________

### CLEARANCE

Typed or printed name of Student __________________________ Signature of Student ____________________________________________________________________________

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: ________________________________________________________________________________

☐ Not cleared for ☐ All sports ☐ Certain sports __________________________ Reason: ____________________________________________________________________________

Recommendations: __________________________________________________________________________________________________________________________________

Name of physician/medical provider [print or type] __________________________ Date __________ Phone ______________

Signature of physician/medical provider ________________________________________________________________________________________________

### PARENT’S OR GUARDIAN’S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. 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 have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian ____________________________________________________________________________ Signature of parent or guardian ____________________________________________________________________________

Date __________ Address __________________________ Insurance (Company name) __________________________

Parent’s Home Phone __________ Parent’s Work Phone __________ Parent’s Cell Phone __________ Additional Phone (if any-specify) ____________

ALL INFORMATION IS TO REMAIN CONFIDENTIAL (Updated 4/19)