**IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION**

**ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. Every year each student (grades 7-12) shall present to the student’s superintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath,* *advanced registered nurse practitioner (ARNP), physician’s assistant or qualified doctor of chiropractic*, to the effect that the studenthas been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of* *this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.***

***QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)***

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_ Female \_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_

Home Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Yes*** | ***No*** | ***Does this student have / ever had?*** | ***Yes*** | ***No Does this student have / ever had?*** |  |
| 1. |  | \_\_\_\_\_ | \_\_\_\_\_ Allergies to medication, pollen, stinging | | 20. \_\_\_\_\_ | \_\_\_\_\_ Head injury, concussion, unconsciousness? |  |
|  |  |  |  | insects, food, etc.? | 21. \_\_\_\_\_ | \_\_\_\_\_ Headache, memory loss, or confusion with |  |
| 2. |  | \_\_\_\_\_ | \_\_\_\_\_ Any illness lasting more than one (1) week? | |  | contact? |  |
| 3. |  | \_\_\_\_\_ | \_\_\_\_\_ Asthma or difficulty breathing during exercise? | | 22. \_\_\_\_\_ | \_\_\_\_\_ Numbness, tingling or weakness in arms or |  |
| 4. |  | \_\_\_\_\_ | \_\_\_\_\_ Chronic or recurrent illness or injury? | |  | legs with contact? |  |
| 5. | \_\_\_\_\_ | | \_\_\_\_\_ Diabetes? | | **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | |  |
| 6. | \_\_\_\_\_ | | \_\_\_\_\_ Epilepsy or other seizures? | | 23. \_\_\_\_\_ | \_\_\_\_\_ Severe muscle cramps or illness when |  |
| 7. |  | \_\_\_\_\_ | \_\_\_\_\_ Eyeglasses or contacts? | |  | exercising in the heat? |  |
| 8. |  | \_\_\_\_\_ | \_\_\_\_\_ Herpes or MRSA? | | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* | |  |
| 9. |  | \_\_\_\_\_ | \_\_\_\_\_ Hospitalizations (Overnight or longer)? | | 24. \_\_\_\_\_ | \_\_\_\_\_ Fracture, stress fracture or dislocated |  |
| 10. | | \_\_\_\_\_ | \_\_\_\_\_ Marfan Syndrome? | |  | joint(s)? |  |
| 11. | | \_\_\_\_\_ | \_\_\_\_\_ Missing organ (eye, kidney, testicle)? | | 25. \_\_\_\_\_ | \_\_\_\_\_ Injuries requiring medical treatment? |  |
| 12. | | \_\_\_\_\_ | \_\_\_\_\_ Mononucleosis or Rheumatic fever? | | 26. \_\_\_\_\_ | \_\_\_\_\_ Knee injury or surgery? |  |
| 13. | | \_\_\_\_\_ | \_\_\_\_\_ Seizures or frequent headaches? | | 27. \_\_\_\_\_ | \_\_\_\_\_ Neck injury? |  |
| 14. | | \_\_\_\_\_ | \_\_\_\_\_ Surgery? | | 28. \_\_\_\_\_ | \_\_\_\_\_ Orthotics, braces, protective equipment? |  |
| **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | | | | | 29. \_\_\_\_\_ | \_\_\_\_\_ Other serious joint injury? |  |
| 15. | | \_\_\_\_\_ | \_\_\_\_\_ Chest pressure, pain, or tightness with | | 30. \_\_\_\_\_ | \_\_\_\_\_ Painful bulge or hernia in the groin area? |  |
|  |  |  |  | exercise? | 31. \_\_\_\_\_ | \_\_\_\_\_ X-rays, MRI, CT scan, physical therapy? |  |
| 16. | | \_\_\_\_\_ | \_\_\_\_\_ Excessive shortness of breath with exercise? | | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* | |  |
| 17. | | \_\_\_\_\_ | \_\_\_\_\_ Headaches, dizziness or fainting during, or | | **32. \_\_\_\_\_** | **\_\_\_\_\_ Has a doctor ever denied or restricted** |  |
|  |  |  |  | after, exercise? |  | **your participation in sports for any** |  |
| 18. | | \_\_\_\_\_ | \_\_\_\_\_ Heart problems (Racing, skipped beats, | | **33. \_\_\_\_\_** | **reason?** |  |
|  |  |  |  | murmur, infection, etc.?) | **\_\_\_\_\_ Do you have any concerns you would** |  |
| 19. | | \_\_\_\_\_ | \_\_\_\_\_ High blood pressure or high cholesterol? | |  | **like to discuss with your health care** |  |
|  |  | ***Yes*** | ***No*** | ***Family History:*** |  | **provider?** |  |
|  |  |  |  |  |
| 34. | | \_\_\_\_\_ | \_\_\_\_\_ Does anyone in your family have Marfan syndrome? | | |  |  |
| 35. | | \_\_\_\_\_ | \_\_\_\_\_ Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50? | | | |  |
| 36. | | \_\_\_\_\_ | \_\_\_\_\_ Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? | | | |  |
| 37. | | \_\_\_\_\_ | \_\_\_\_\_ Has anyone in your family had unexplained fainting, seizures, or near drowning? | | | |  |
| 38. | | \_\_\_\_\_ | \_\_\_\_\_ Does anyone in your family have asthma? | |  |  |  |
| 39. | | \_\_\_\_\_ | \_\_\_\_\_ Do you or someone in your family have sickle cell trait or disease? | | | |  |

*Use this space to explain any* ***“YES”*** *answers from above (questions #1-38) or* ***to provide any additional information****:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:

A. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

42. Year of last known vaccination: Tetanus: \_\_\_\_\_\_\_\_\_ Meningitis: \_\_\_\_\_\_\_\_\_\_ Influenza: \_\_\_\_\_\_\_\_\_\_

1. What is the most and least you have weighed in the past year? ***Most*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Least*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you happy with your current weight? ***Yes*** \_\_\_\_\_ ***No*** \_\_\_\_\_ ***If no***, how many pounds would you like to lose or gain?

*Lose \_\_\_\_\_ Gain \_\_\_\_\_*

***FOR FEMALES ONLY:***

1. How old were you when you had your first menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many periods have you had in the last 12 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Page 1 of 2, Physical Examination Record & Parent’s/Guardian’s Release is on the reverse side*

***PHYSICAL EXAMINATION RECORD*** (To be completed by a licensed medical professional as designated in Article VII36.14(1). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for*** ***regular health maintenance examinations.***

Athlete’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pulse \_\_\_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_/\_\_\_\_\_ *(Repeat, if abnormal \_\_\_\_\_\_/\_\_\_\_\_\_)* | | | | Vision R 20/\_\_\_\_\_\_\_\_\_ L 20/\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | ***NORMAL*** | ***ABNORMAL FINDINGS*** | ***INITIALS*** |
| 1. | Appearance (esp. Marfan’s ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 2. | Eyes/Ears/Nose/Throat | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 3. | Pupil Size (Equal/Unequal) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 4. | Mouth & Teeth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 5. | Neck | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 6. | Lymph Nodes | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 7. | Heart (Standing & Lying) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 8. | Pulses (esp. femoral) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 9. | Chest & Lungs | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 10. Abdomen | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 11. Skin | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 12. | Genitals - Hernia | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 13. | Musculoskeletal - ROM, |  |  |  |

strength, etc. *(See questions 24-31)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



14. Neurological \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Comments regarding abnormal findings:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***LICENSED MEDICAL PROFESSIONAL’S ATHLETIC PARTICIPATION RECOMMENDATION*S**

\_\_\_\_\_ **FULL & UNLIMITED PARTICIPATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_\_ **LIMITED PARTICIPATION** - *May* ***NOT*** *participate in the following (checked):* | | | |  |
| \_\_\_\_\_ Baseball | \_\_\_\_\_ Basketball | \_\_\_\_\_ Bowling | \_\_\_\_\_ Cross Country \_\_\_\_\_ Football \_\_\_\_\_ Golf \_\_\_\_\_ Soccer | |
| \_\_\_\_\_ Softball | \_\_\_\_\_ Swimming | \_\_\_\_\_ Tennis | \_\_\_\_\_ Track \_\_\_\_\_ Volleyball | \_\_\_\_\_ Wrestling |
| \_\_\_\_\_ **CLEARANCE PENDING** **DOCUMENTED FOLLOW UP OF**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| \_\_\_\_\_ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Licensed Medical Professional’s Name** *(Printed)* | | |  | **Date of PPE** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Licensed Medical Professional’s Signature** | | |  | **Phone** |

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

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also **give my permission** for the team’s physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian *(Printed)* Signature of Parent of Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street/PO Box, City, State, Zip) Phone Number

*This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for*

|  |  |
| --- | --- |
| *use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are* |  |
| *encouraged NOT to change this form from its published format. Additional school forms can be attached to this form.* | *9/12* |