

# Sports Physicals!

\$15.00

Thursday, June 17th

6 – 8 PM

## CHS Gymnasium

(Provided by the physicians of the  
Center for Orthopedic Surgery & Sports Medicine)

Athletes must have a signed consent form at time of  
exam.

Forms available online, in Athletic Training Room or  
from CHS Coaches.



180 South 3rd, Suite 100  
Belleville, IL 62220  
(618) 641-5800  
(618) 641-5825 FAX

**CONSENT FOR PHYSICAL EVALUTATION AND TREATMENT**

I, \_\_\_\_\_, hereby give consent to St. Elizabeth's Hospital and the Center for Orthopedic Surgery and Sports Medicine staff to complete a physical evaluation, diagnostic tests, to include radiology exams and laboratory tests, and treatment on my child, \_\_\_\_\_ in the event of musculoskeletal injury or medical condition as a result of participating in my child's school athletic program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# Preparticipation Examination

To be completed by athlete or parent prior to examination.

Name \_\_\_\_\_ Sport/Position \_\_\_\_\_  
           Last                      First                      Middle

Social Security Number \_\_\_\_\_ School Year \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Phone No. \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Class \_\_\_\_\_ Student ID No. \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Phone No. \_\_\_\_\_

Family Doctor \_\_\_\_\_ City/State \_\_\_\_\_

Phone No. \_\_\_\_\_

## Past Medical History

	Yes	No	If yes, please explain (what, where, when)
1. Presently taking medication (including birth control pills)?	_____	_____	_____
2. Have you been diagnosed with asthma?	_____	_____	_____
3. Have you been prescribed by a physician to use any asthma medication?	_____	_____	_____
4. Do you have a current consent form to self-administer the asthma medication on file with your school?	_____	_____	_____
5. Allergic to medicine, foods, bee stings?	_____	_____	_____
6. Wears any appliances—glasses, contact lenses?	_____	_____	_____
7. History of braces, chipped teeth, bridges?	_____	_____	_____
8. Has ongoing medical problem?	_____	_____	_____
9. Had serious or significant illness in past?	_____	_____	_____
10. Any past surgical operations, accidents, non-sports or related injuries?	_____	_____	_____
11. Any past injuries directly related to sports?	_____	_____	_____
12. Any hospitalization not explained above?	_____	_____	_____
13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?	_____	_____	_____
14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?	_____	_____	_____
15. Heart			
Have you ever passed out during or after exercise?	_____	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____	_____
Do you get tired more quickly than your friends do during exercise?	_____	_____	_____
Have you ever had racing of your heart or skipped heartbeats?	_____	_____	_____

	Yes	No	If yes, please explain (what, where, when)
Have you had high blood pressure or high cholesterol?	_____	_____	_____
Have you ever been told you have a heart murmur?	_____	_____	_____
Has any family member or relative died of heart problems or of sudden death before age 50?	_____	_____	_____
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	_____	_____	_____
Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____	_____
Has anyone in your family had a heart attack before the age of 50?	_____	_____	_____
16. Head and Nerve			
Have you ever had a head injury or concussion?	_____	_____	_____
Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	_____
Have you ever had a seizure?	_____	_____	_____
Do you have frequent or severe headaches?	_____	_____	_____
Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____	_____
Have you ever had a stinger, burner or pinched nerve?	_____	_____	_____
17. Last tetnus shot?	_____	_____	Date _____
18. Last eye exam?	_____	_____	Date _____
19. Last menstrual period (if women)	_____	_____	Date _____

## Personal Habits

	Yes	No
1. Smoking/smokeless tobacco	_____	_____
2. Alcohol/non-medical drugs: marijuana, cocaine, etc	_____	_____
3. Steroids	_____	_____
4. Eating Disorders - weight loss or gain?	_____	_____

Review of systems (Please check if you have any problems with any of the following areas of your body)

_____ Skin	_____ Lungs	_____ Shoulders, Arms,
_____ Head	_____ Heart	_____ Hands
_____ Eyes	_____ Abdomen	_____ Hips, Legs, Feet
_____ Ears	_____ Back	_____ Muscles—Strength,
_____ Nose	_____ Urination,	_____ Feeling
_____ Mouth/Throat	_____ Bowel Control	_____ Mental, Emotional
_____ Nutrition,	_____ Genital (including	_____ Fatigue
_____ Weight Control	_____ menstrual for women)	_____ Other: What?
_____ Neck		_____

I certify that the above information is correct to the best of my knowledge.

Student Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**Both Student And Parent/Guardian Signatures Are Mandatory**

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Pulse: resting \_\_\_\_\_ 15 hops \_\_\_\_\_ after 2 minutes \_\_\_\_\_  
 Visual Acuity: Eyes (R) 20/ \_\_\_\_\_ w/o glasses \_\_\_\_\_ (L) 20/ \_\_\_\_\_ w/ glasses \_\_\_\_\_

Other Testing	Normal	Abnormal Findings
1. General	_____	_____
2. Skin	_____	_____
3. HEENT	_____	_____
4. Teeth (Dental Exam)	_____	_____
5. Neck	_____	_____
6. Lungs	_____	_____
7. Heart (Sit and Stand)	_____	_____
8. Abdomen	_____	_____
9. Genitalia	_____	_____
10. Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Shin/Calf	_____	_____
Ankle/Leg	_____	_____
Foot	_____	_____
11. Peripheral Pulses	_____	_____
12. Neurologic	_____	_____
13. Mental Status	_____	_____
14. Marfan Screen	_____	_____

**Other Tests (optional)**  
 \_\_\_\_\_ Auditory \_\_\_\_\_ U/V \_\_\_\_\_ EKG  
 \_\_\_\_\_ % Body Fat \_\_\_\_\_ Drug Screen \_\_\_\_\_ Chest X-Ray  
 \_\_\_\_\_ Hgb/Hct \_\_\_\_\_ SMAC \_\_\_\_\_ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_

Additional Comments:

Examination Date \_\_\_\_\_ Physicians Signature \_\_\_\_\_  
 Physician's Assistant Signature\* \_\_\_\_\_  
 Advanced Nurse Practitioner Signature\* \_\_\_\_\_

\* effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Student's Name \_\_\_\_\_ School Name \_\_\_\_\_

**Consent Form to self administer asthma medication**  
 (not needed if current form is already on file with school)

**Parent Consent**

I, \_\_\_\_\_, do hereby give my son/daughter, \_\_\_\_\_, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician Consent**

As a patient under my care, \_\_\_\_\_, is prescribed to self-administer the following asthma medication.

Medication \_\_\_\_\_

Purpose \_\_\_\_\_

Dosage \_\_\_\_\_

Time/Special Circumstances \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**IHSA Steroid Testing Policy Consent to Random Testing**

In January 2008, the Illinois High School Association's Board of Directors approved a plan developed by the IHSA's Sports Medicine Advisory Committee to implement random testing for steroids and performance-enhancing dietary supplements of teams and individuals qualifying for state finals competition.

Beginning with the 2008-09 school term, any student-athlete who ingests or otherwise uses substance from the association's banned drug classes, without written permission by a licensed physician, to treat a medical condition, violates IHSA By-law 2.170 and its subsections, and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school.

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

A complete list of the current IHSA Banned Drug Classes can be accessed at [http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA\\_banned\\_list-2007-08.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_list-2007-08.pdf).

Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent-guardian \_\_\_\_\_ Date \_\_\_\_\_

