

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

2019-2020 SPORTS QUALIFYING PHYSICAL EXAMINATION MEDICAL ELIGIBILITY FORM
Minnesota State High School League

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_
Address: \_\_\_\_\_
Home Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Mobile Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
School: \_\_\_\_\_ Grade: \_\_\_\_\_

NAME
Last

I certify that the above student has been medically evaluated and is deemed medically eligible to: (Check Only One Box)

- (1) Participate in all school interscholastic activities without restrictions.
(2) Participate in any activity not crossed out below.

Table with 3 columns: Collision Contact Sports, Limited Contact Sports, Non-contact Sports. Lists various sports like Basketball, Baseball, Badminton, etc.

Table with 3 columns: A. Low (<40% Max O2), B. Moderate (40-70% Max O2), C. High (>70% Max O2). Rows represent increasing static component (I. Low, II. Moderate, III. High) and increasing dynamic component (A, B, C).

First

ID#

Physical Date

- (3) Requires additional evaluation before a final recommendation can be made.
Additional recommendations for the school or parents: \_\_\_\_\_

- (4) Not medically eligible for:
All Sports
Specific Sports
Specify \_\_\_\_\_

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...

I have examined the student named on this form and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. The athlete does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form...

Provider Signature \_\_\_\_\_ Date of Exam \_\_\_\_\_
Print Provider Name: \_\_\_\_\_
Office/Clinic Name \_\_\_\_\_ Address: \_\_\_\_\_
City, State, Zip Code \_\_\_\_\_
Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses c history of disease); polio (3-4 doses); influenza (annual)]
Up-to-date (see attached school documentation) Not reviewed at this visit

IMMUNIZATIONS GIVEN TODAY: \_\_\_\_\_

EMERGENCY INFORMATION

Allergies \_\_\_\_\_
Other Information \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_
Telephone: (H) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (W) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (C) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Personal Provider \_\_\_\_\_ 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]

2019-2020 SPORTS QUALIFYING PHYSICAL HISTORY FORM

Minnesota State High School League

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_
Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_
Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

Past and current medical conditions: \_\_\_\_\_
Have you ever had surgery? If yes, list all past surgeries. \_\_\_\_\_
Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

Table with 5 columns: Problem, Not at all, Several days, Over half the days, Nearly every day. Rows include: Feeling nervous, anxious, or on edge; Not being able to stop or control worrying; Little interest or pleasure in doing things; Feeling down, depressed, or hopeless.

(If the sum of responses to questions 1 & 2 or 3 & 4 are >or = 3, evaluate.)

Circle Question Number (1) of questions for which the answer is unknown.

Circle Y for Yes or N for No

GENERAL QUESTIONS

- 1. Do you have any concerns that you would like to discuss with your provider?
2. Has a provider ever denied or restricted your participation in sports for any reason?
3. Do you have any ongoing medical issues or recent illness?

HEART HEALTH QUESTIONS ABOUT YOU\*

- 4. Have you ever passed out or nearly passed out during or after exercise?
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?
7. Has a doctor ever told you that you have any heart problems?
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.
9. Do you get light-headed or feel shorter of breath than your friends during exercise?
10. Have you ever had a seizure?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY\*

- 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

BONE AND JOINT QUESTIONS

- 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?

MEDICAL QUESTIONS

- 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?
22. Have you ever become ill while exercising in the heat?
23. Do you or does someone in your family have sickle cell trait or disease?
24. Have you ever had or do you have any problems with your eyes or vision?
25. Do you worry about your weight?
26. Are you trying to or has anyone recommended that you gain or lose weight?
27. Are you on a special diet or do you avoid certain types of foods or food groups?
28. Have you ever had an eating disorder?

FEMALES ONLY

- 29. Have you ever had a menstrual period?
30. How old were you when you had your first menstrual period?
31. When was your most recent menstrual period?
32. How many periods have you had in the past 12 months?

Notes: \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_  
Date: \_\_\_/\_\_\_/\_\_\_

Signature of parent or guardian: \_\_\_\_\_

## 2019-2020 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

### Minnesota State High School League

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**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, pipe, e-cigarette smoking, or vaping, 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 alcohol drinks, 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 Findings	Initials*
<b>Appearance</b>			
Circle any Marfan stigmata present	→	Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
<b>HEENT</b>			
Eyes			
Fundoscopy			
Pupils			
Hearing			
<b>Cardiovascular<sup>a</sup></b>			
Describe any murmurs present (standing, supine, +/- Valsalva)	→		
Pulses (simultaneous femoral & radial)			
<b>Lungs</b>			
<b>Abdomen</b>			
<b>Tanner Staging (optional)</b>	Circle	I II III IV V	
<b>Skin</b> (No HSV, MRSA, Tinea corporis)			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional (Double-leg squat test, single-leg squat test, and box drop or step drop test)			

<sup>a</sup>Consider ECG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings

\* For Multiple Examiners

Additional Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Maintenance:  Lifestyle, health, immunizations, & safety counseling     Discussed dental care & mouthguard use  
 Discussed Lead and TB exposure – (Testing indicated / not indicated)     Eye Refraction if indicated