



**GRUNDY COUNTY  
MEMORIAL HOSPITAL**

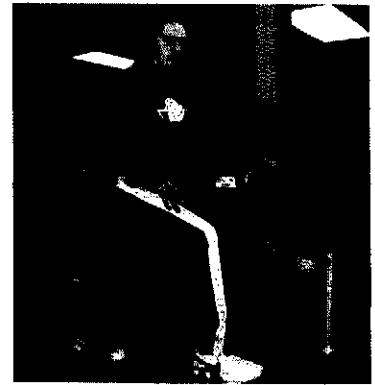
A PARTNER OF ALLEN HOSPITAL

**Sports Physical Permission Form**

My child, \_\_\_\_\_, has my permission to have his/her athletic pre-participation physical examination completed by the providers at Grundy County Memorial Hospital.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date



## **Sports Physicals**

**A Fundraiser to Support the GCHS Athletic Trainer**

**Monday, August 2, 2010**

**5:00 p.m. – 7:30 p.m.**

**Grundy County Memorial Hospital**

**Call (319) 824-5081 or (888) 824-5081 to schedule**

**Athletes must bring their Athletic Pre-Participation Physical Examination Form to the hospital. The health history section of this form must be filled out prior to the sports physical.**

**\$30.00 due at time of physical**

**Please make checks payable to: Grundy Center High School**

**Participants will receive a comprehensive physical including:**

- **Medical Evaluation**
- **Physical Therapy and Chiropractic Screening**
- **Vision Screening**
- **Exercise Prescription (if needed)**

**Special thanks to**

**Paul Eberline, D.C., Becky Frisch, PA-C,  
Frank Lamp, M.D., and Edward Shuherk, M.D.  
and Grundy County Memorial Hospital**



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# 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 student has 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 \_\_\_\_\_ Phone # \_\_\_\_\_  
 Parent's/Guardian's Name \_\_\_\_\_ Date \_\_\_\_\_  
 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.)*

- |   |   |
|---|---|
| <p><b>Yes No Has this student ever had?</b></p> <p>1. _____ Chronic or recurrent illness or injury?<br/>                 2. _____ Any illness lasting more than one (1) week?<br/>                 3. _____ Mononucleosis or Rheumatic fever?<br/>                 4. _____ Hospitalizations (Overnight or longer)?<br/>                 5. _____ Surgery, other than tonsillectomy?<br/>                 6. _____ Missing organ (eye, kidney, testicle)?<br/>                 7. _____ Allergies to pollen, stinging insects, food, etc.?<br/>                 8. _____ High blood pressure or high cholesterol?<br/>                 9. _____ Heart problems (Racing, murmur, skipped beats, infection, etc.?)<br/>                 10. _____ Chest pressure or pain with exercise?<br/>                 11. _____ Dizziness or fainting with exercise?<br/>                 12. _____ Excessive shortness of breath with exercise?<br/>                 13. _____ Seizures or frequent headaches?<br/>                 14. _____ Head injury, concussion, unconsciousness?<br/>                 15. _____ Numbness, tingling or weakness in arms or legs with contact?<br/>                 16. _____ Headache, memory loss, or confusion with contact?<br/>                 17. _____ Severe muscle cramps or become ill when exercising in the heat?</p> <p><b>Yes No Family History:</b></p> <p>31. _____ Does anyone in your family have Marfan syndrome?<br/>                 32. _____ Has anyone in your family died suddenly for no apparent reason?<br/>                 33. _____ Has anyone in your family had a heart attack at less than 55 years of age?</p> | <p><b>Yes No Has this student ever had?</b></p> <p>18. _____ Asthma?<br/>                 19. _____ Epilepsy, or other seizures?<br/>                 20. _____ Diabetes?<br/>                 21. _____ Herpes infection?<br/>                 22. _____ Marfan Syndrome?<br/>                 23. _____ Eyeglasses or contact lenses?</p> <p><b>Yes No Is there a history of?</b></p> <p>24. _____ Injuries requiring medical treatment?<br/>                 25. _____ Neck injury?<br/>                 26. _____ Knee injury or surgery?<br/>                 27. _____ Other serious joint injuries?<br/>                 28. _____ Use of protective equipment or braces?</p> <p>*****</p> <p>29. _____ <b>Has a doctor ever denied or restricted your participation in sports for any reason?</b><br/>                 30. _____ <b>Do you have any concerns that you would like to discuss with your doctor?</b></p> |
|---|---|

Use this space to explain any "YES" answers from above (questions #1-33) or to provide any additional information:

\_\_\_\_\_

\_\_\_\_\_

34. \_\_\_\_\_ Are you allergic to any prescription or over-the-counter medications? *If yes, list:* \_\_\_\_\_
35. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:  
 A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_
36. Year of last known: Tetanus (lockjaw) vaccination: \_\_\_\_\_ Meningitis vaccination: \_\_\_\_\_
37. What is the most and least you have weighed in the past year? **Most** \_\_\_\_\_ **Least** \_\_\_\_\_
38. Are you happy with your current weight? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**FOR FEMALES ONLY:**

1. How old were you when you had your first menstrual period? \_\_\_\_\_
2. In the past 12 months, what is the longest time you have gone between menstrual periods? \_\_\_\_\_

**PHYSICAL EXAMINATION RECORD** (To be completed by a licensed medical professional as designated in Article VII 36.14(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 24-28)			
14. Neurological			

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

**LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS**

       **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 \_\_\_\_\_

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 certainly be attached to it.*

PARTICIPANT'S NAME \_\_\_\_\_

GRADE: \_\_\_\_\_

**ATHLETE / PARENT - GUARDIAN**

**Informed Consent Sheet**

We certify that we have read and understand the cautions, considerations and responsibilities required for participation in the following programs. (PLEASE CIRCLE ALL THE ACTIVITIES THIS STUDENT WILL BE PARTICIPATING IN DURING THE CURRENT SCHOOL YEAR.)

Football—Volleyball—Cross Country—Girls Basketball—Boys Basketball—Wrestling—Girls Track—Boys Track—Girls Golf—Boys Golf—Girls Tennis—Boys Tennis—Baseball—Softball—Football Cheerleader—Basketball Cheerleader—Wrestling Cheerleader—Drill Team—GC Jazz—Marching Band—Drama

I also am aware the participation in all sports or activities on rare occasions can lead to serious, perhaps catastrophic injury or death. Being aware of this fact I give my son/daughter permission to participate in athletics/activities at GRUNDY CENTER JR-SR HIGH SCHOOL.

This application to compete in interscholastic athletics/activities for the above school is entirely voluntary on my part. I also give permission for the team physician to give treatment at an athletic/activity event for any injury.

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**INSURANCE COVERAGE WAIVER**

WE HAVE OUR OWN PERSONAL ACCIDENT OR MEDICAL INSURANCE WHICH WILL COVER THE ABOVE NAMED PARTICIPANT IN THE EVENT OF AN INJURY WHILE PARTICIPATING IN GRUNDY CENTER COMMUNITY SCHOOL ACTIVITIES.

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

This sheet is to be **returned** to the High School Office **PRIOR** to the start of the fall activities.

If this participant is in the ninth grade and will be playing football please complete the backside of this sheet.

PARTICIPANT'S NAME \_\_\_\_\_

GRADE: \_\_\_\_\_

**CONSENT FORM  
NINTH GRADE PARTICIPATION IN VARSITY FOOTBALL**

The official school participation rules allow ninth grade students to participate with the varsity in practice and to play on the varsity team only with the written consent of the parents or guardian.

This is to certify I (we) understand the rules and hereby give my (our) consent for \_\_\_\_\_ to participate in practice and in interscholastic games with the varsity squad.

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

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

This form must be signed and returned to the Activities Director. Both parents should sign where applicable. Your son will not be allowed to participate with the varsity until this form is signed and properly filed.

\*\*\*\*\*

**This section is to be completed by the player.**

**FOOTBALL HELMET WAIVER**

Date \_\_\_\_\_

I have read, and the coaches have explained the helmet warning. I understand that it is my responsibility to report any damage or defects in my helmet to the coaching staff. I also understand that a helmet should not be used to butt, ram or spear an opposing player. This is in violation of the football rules and can result in severe head, brain or neck injury, paralysis or death to you and possible injury to your opponent. Inspect your helmet prior to each usage.

**NO HELMET CAN PREVENT ALL INJURIES**

Athlete's signature \_\_\_\_\_

The sticker shown below must be displayed on the outside of the helmet **at all times.**