



# UHSAA

## FORM A



**USE THIS FORM FOR INITIAL PHYSICAL EXAM**

*Instructions for use of pre-participation (athletic)  
Health Examination and Consent Form*

**Instructions for completing FORM A**

**COMPLETING THIS FORM.**

1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent or Guardian is to complete page I of Form A and the Disclosure and Consent Document. Please note student and parent are to sign both forms.
3. Physician/Provider is to complete and sign the physical examination on page 2.
4. Entire completed form is to be returned to school administration.

**SUBMITTING THIS FORM.**

- 1 - School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files,.

A health examination must be performed and the Preparticipation Physical Evaluation (FORM A) must be completed before any student may participate in athletic activities sponsored by this Association. Clearance Form (Form B) must be completed by the Parent each subsequent year. A re-evaluation physical examination will be required if any changes appear for questions 1-16 on the Clearance Form (Form B). Forms A and B along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP).

**PLEASE MAKE ALL NECESSARY COPIES OF THIS FORM FOR YOUR STUDENTS. MULTIPLE COPIES ARE NOT PROVIDED BY THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION.**

# UHSAA

## Participant & Parental Disclosure and Consent Document

**PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE PARENT OR GUARDIAN TO NOTIFY THE SCHOOL IF THERE ARE ANY UNIQUE INDIVIDUAL PROBLEMS THAT ARE NOT LISTED ON HEALTH EXAMINATION FORM A OR B.**

Is the student covered by health/accident insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of health insurance provider \_\_\_\_\_

If none, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CONSENT FORM

(Parent or Guardian and Student Permission and Approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation. I recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death. I also understand that a copy of this form will remain in the student's school.

I agree that if my student's health changes and would alter this evaluation, I will notify the school within 10 days.

**PARENT OR GUARDIAN SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.

**SIGNATURE OF STUDENT** \_\_\_\_\_

**DATE** \_\_\_\_\_

*THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.*

# Pre participation Physical Evaluation

HISTORY

DATE OF EXAM \_\_\_\_\_

Name _____ Sex _____ Age _____ Date of birth _____	
Grade _____ School _____ Sport(s) _____	
Address _____ Phone _____	
Personal physician _____	
In case of emergency, contact	
Name _____ Relationship _____	Phone (H) _____ (W) _____

Explain "Yes" answers below.  
Circle questions you don't know the answers to.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?<br>Do you have an ongoing or chronic illness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?<br>Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an Inhaler?<br>Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging Insects)?<br>Have you ever had a rash or hives develop during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you get tired more quickly than your friends do during exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Have you had high blood pressure or high cholesterol?<br>Have you ever been told you have a heart murmur?<br>Has any family member or relative died of heart problems or of sudden death before age 50?<br>Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?<br>Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion?<br>Have you ever been knocked out, become unconscious, or lost your memory?<br>Have you ever had a seizure?<br>Do you have frequent or severe headaches?<br>Have you ever had numbness or tingling in your arms, hands, legs, or feet?<br>Have you ever had a stinger, burner, or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?<br>Do you have asthma?<br>Do you have seasonal allergies that require medical treatment?  | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision?<br>Do you wear glasses, contacts, or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain, or swelling after injury?<br>Have you broken or fractured any bones or dislocated any joints?<br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?<br><i>If yes, check appropriate box and explain below</i>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip<br><input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh<br><input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee<br><input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf<br><input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle<br><input type="checkbox"/> Upper arm <input type="checkbox"/> Foot |                          |                          |
| 13. Do you want to weigh more or less than you do now?<br>Do you lose weight regularly to meet weight requirements for your sport?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you feel stressed out?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Record the dates of your most recent immunizations (shots) for:<br>Tetanus _____ Measles _____<br>Hepatitis B _____ Chickenpox _____  |                          |                          |

**FEMALES ONLY**

16. When was your first menstrual period? \_\_\_\_\_  
When was your most recent menstrual period? \_\_\_\_\_  
How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
How many periods have you had in the last year? \_\_\_\_\_  
What was the longest time between periods in the last year? \_\_\_\_\_  
Explain "Yes" answers here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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# Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ )

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

\*Stabon-based examination only

## CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_ ) MD, DO, PAC, RNP, or DC

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# FORM B

USE THIS FORM WHEN PREVIOUS PRE-PARTICIPATION



(Athletics) EXAM IS ON FILE



## Instructions for completing FORM B

- 1 PLEASE TYPE OR PRINT FIRMLY and LEGIBLY
2. Parent or Guardian is to complete back page of Form B and sign it every year.
3. Entire completed form is to be returned to school administration every year.
- 4, **School Personnel** should review the form to assure it is completed properly,  
A recommendation to clear a student for participation or require a re-evaluation  
physical exam is made and based upon this form. Every year the back page of this  
form (Form B) must be completed by parent and if there are any changes on any  
answers from the original examination then CLEARANCE FORM B (below) must be  
completed and signed by an MD(Medical Doctor), DO(Doctor of Osteopathy),  
PAC(Physician's Assistant), RNP(Registered Nurse Practitioner), or DC(Chiropractic Physician),
5. ORIGINAL copy is to be retained in school files,

PLEASE MAKE ALL NECESSARY COPIES OF THIS FORM FOR YOUR STUDENTS. MULTIPLE COPIES ARE NOT PROVIDED BY THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION.

## Preparticipation Physical Evaluation CLEARANCE FORM

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not cleared for \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of MD, DO, PAC, DC, or RNP \_\_\_\_\_

# Preparticipation Physical Evaluation

HISTORY \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal physician \_\_\_\_\_  
*In case of emergency, contact*  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers below.  
 Circle questions you don't know the answers to.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?<br>Do you have an ongoing or chronic illness?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?<br>Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an Inhaler?<br>Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging Insects)?<br>Have you ever had a rash or hives develop during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you get tired more quickly than your friends do during exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Have you had high blood pressure or high cholesterol?<br>Have you ever been told you have a heart murmur?<br>Has any family member or relative died of heart problems or of sudden death before age 50?<br>Have you had a severe viral Infection ( <b>for example</b> , myocarditis or mononucleosis) within the last month?<br>Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion?<br>Have you ever been knocked out, become unconscious, or lost your memory?<br>Have you ever had a seizure?<br>Do you have frequent or severe headaches?<br>Have you ever had numbness or tingling in your arms, hands, legs, or feet?<br>Have you ever had a stinger, burner, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?<br>Do you have asthma?<br>Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                              | No                                 |
|--|----------------------------------|------------------------------------|
| I 0. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 1 1. Have you had any problems with your eyes or vision?<br>Do you wear glasses, contacts, or protective eyewear?  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 12. Have you ever had a sprain, strain, or swelling after injury?<br>Have you broken or fractured any bones or dislocated any joints?<br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?<br>If yes, check appropriate box and explain below | <input type="checkbox"/>         | <input type="checkbox"/>           |
| <input type="checkbox"/> Head  | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Neck  | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper arm   |                                  | <input type="checkbox"/> Foot      |
| 13. Do you want to weigh more or less than you do now?<br>Do you lose weight regularly to meet weight requirements for your sport?   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 14. Do you feel stressed out?  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 1 5. Record the dates of your most recent Immunizations (shots) for:<br>Tetanus _____ Measles _____<br>Hepatitis B _____ Chickenpox _____  |                                  |                                    |

**FEMALES ONLY**

16. When was your first menstrual period? \_\_\_\_\_  
 When was your most recent menstrual period? \_\_\_\_\_  
 How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_  
 What was the longest time between periods in the last year? \_\_\_\_\_

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.  
 Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_