SUGGESTED
SPORTS CANDIDATES' QUESTIONNAIRE

(To be completed by parents or family physician)

Name____ Date of Birth

____

Home Address

____

Parents' Address _____________________________________ Tel. No.

____

1. Has had injuries requiring medical attention. ☐Yes ☐No
2. Has had an illness lasting more than a week. ☐Yes ☐No
3. Is under a physician's care now. ☐Yes ☐No
4. Takes medication now. ☐Yes ☐No
5. Wears glasses ☐Yes ☐No

   Contact lenses ☐Yes ☐No
6. Has had a surgical operation ☐Yes ☐No
7. Has been in hospital (except for tonsillectomy) ☐Yes ☐No
8. Do you know of any reason why this individual should not

   participate in sports? ☐Yes ☐No

Please explain any "Yes" answers to above questions:

____
__
____
__
____
__

9. Has had complete poliomyelitis immunization by oral

   vaccine (Sabin) ☐Yes ☐No
10. Most recent tetanus toxoid for immunization ___________________
(date)

Was this a booster? ☐Yes ☐No

11. Has seen a dentist within the past 6 months ☐Yes ☐No

Date: ______________________

____
Parent or Physician

ATHLETES PHYSICAL EXAMINATION FORM

(Cooperatively prepared by the National Federation of State High School Associations and the Committee of Medical Aspects of Sports of the American Medical Association) Health examination for athletes should be rendered after August 1 preceding school year concerned.

____

(Please Print) Name of Student City and School

Grade ______ Age ______ Height _____________ Weight ________ Blood Pressure __________________

Significant Past Illness or Injury____

Eyes _____________ R20/_______; L20/_______; Ears _____________ Hearing R_______/15;L_______/15

Respiratory ____

Cardiovascular ____

Liver ________________________ Spleen ____________________________ Hernia ___________________

Musculoskeletal _________________________________Skin _____________________________________

Neurological __________________________________Genitalia ____________________________________

Laboratory: Urinalysis ______________________________ Other: __________________________________

Comments ____

Completed Immunizations: Polio _______________________ Tetanus ______________________________

Date Date

Instructions for use of card – Other ____

"I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities, **EXCEPT THOSE CROSSED OUT BELOW**."

BASEBALL	FIELD	GOLF	SKIIING	SWIMMING
BASKETBALL	HOCKEY	GYMNASTICS	SOCCER	TENNIS
CROSS	FOOTBALL	ROWING	SOFTBALL	TRACK
COUNTRY	HOCKEY	SKATING	SPEEDBALL	VOLLEYBALL
				*WRESTLING

OTHERS____________________________________

*Estimated desirable weight level: ___________ pounds.

Date of Examination:______________________

Signed:____

Examining Physician

Physician's

Address:____Telephone:____________________

STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM

Name of

Student:____

First Last Middle Initial

Name of School: ____

Date:____________________

Date of Birth: ___________________ Place of

Birth:____

This application to compete in interscholastic athletics for the above high 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 State Association.

Signature of Student:____

PARENT'S OR GUARDIAN'S PERMISSION

"I hereby give my consent for the above named student (1) to represent his/her school in athletic activities except those crossed out on this form by the examining physician, provided that such athletic activities are approved by the State Association; (2) to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel, I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic activities or such travel."

Date:____________________ Signature of Parent or Guardian: ____
Address:____

NOTE: This form is to be filled out completely and filed at the office of the school principal before student is allowed to practice and/or compete.

SUGGESTED RETURN TO PLAY FORM*

Committee on the Medical Aspects of Sports of the American Medical Association and the National Federation of State High School Associations.

Record No.____________________________

TO BE COMPLETED BY STUDENT

1. Identification
Name____ School__________________________________

Home Address____ Phone Number____________________________
Grade_____________________ Age_______________________

TO BE COMPLETED BY PHYSICIAN

2. Injury (Illness) Information
Time and Date of Injury_____________________________________ Injured in Practice_______________
Game________________
Other_________________
Sport _____________________________________ Position Played ______________________________
Coach_________________________ Office_______________________ Phone Number_____________________

3. Description of Injury

4. Referred

5. Recommendations
- No restrictions (discharged) as of (date): ____
- No practice or play until (date): ____
- Expected Return to Activity (definite date after further evaluation): ________________________________
- Light running only – No contact ____
- Regular practice but no contact ____
- Return for further care – No_________
  Yes_______
- Other ____
  Date _______________________________
  Physician ____Phone Number ____________________

*It is recommended that the physician keep original and forward copies to the parents or guardian and coach.

8 **TABLE.** Recommendations for Participation in Competitive Sport

	Contact Collision	Limited Contact Impact	Strenuous	Noncontact Moderately Strenuous	Nonstrenuous
Atlantoaxial Instability	No	No	Yes*	Yes	Yes
*Swimming no butterfly, breast stroke, or diving starts					
Acute Illnesses	*	*	*	*	*
* Needs individual assessment, eg, contagiousness to others, risk of worsening illness					
Cardiovascular					
Carditis	No	No	No	No	No
Hypertension	Yes	Yes	Yes	Yes	Yes
Mild	Yes	Yes	Yes	Yes	Yes
Moderate	*	*	*	*	*
Severe	*	*	*	*	*
Congenital Heart Disease	*	*	*	*	*
* Needs individual assessment	†	†	†	†	†
† Patients with mild forms can be allowed a full range of physical activities; patients with moderate or severe forms, or who are postoperative, should be evaluated by a cardiologist before athletic participation.					
Eyes					
Absence or loss of function of one eye	*	*	*	*	*
Detached retina	†	†	†	†	†
* Availability of American Society for Testing and Materials (ASTM) approved eye guards may allow competitor to participate in most sports, but this must be judged on an individual basis.					
† Consult ophthalmologist					
Inguinal Hernia	Yes	Yes	Yes	Yes	Yes
Kidney: Absence of One	No	Yes	Yes	Yes	Yes
Liver: Enlarged	No	No	Yes	Yes	Yes
Musculoskeletal Disorders	*	*	*	*	*
* Needs individual assessment					
Neurologic					
History of serious head or spine trauma, repeated Concussions or craniotomy	*	*	Yes	Yes	Yes
Convulsive Disorder					
Well Controlled	Yes	Yes	Yes	Yes	Yes
Poorly Controlled	No	No	Yes †	Yes	Yes ‡
* Needs individual assessment					
† No Swimming or Weight Lifting					
‡ No archery or riflery					
Ovary: Absence of One	Yes	Yes	Yes	Yes	Yes
Respiratory					
Pulmonary Insufficiency	*	*	*	*	Yes
Asthma	Yes	Yes	Yes	Yes	Yes
* May be allowed to compete if oxygenation remains satisfactory during a graded stress test.					
Sickle Cell Trait	Yes	Yes	Yes	Yes	Yes
Skin: Boils, Herpes, Impetigo, Scabies	*	*	Yes	Yes	Yes
* No gymnastics with mats, marital arts, wrestling, or contact sports until no contagious.					
Spleen: Enlarged	No	No	No	Yes	Yes
Testicle: Absence or Undescended	Yes*	Yes*	Yes	Yes	Yes
* Certain sports may require protective cup.					

Certain activities, such as skiing, are not inherently "contact sports". Yet, when competitors fall and collide with the ground, they are as much at risk as participants in the more traditional collision/contact sports. Hence, we have included such sports in a group called "limited contact/impact".

A list of all medical conditions that would disqualify athletes from participation would be nearly endless. Therefore, a concise table that can be consulted quickly and easily was thought to be most helpful. These, then, are the committee's recommendations for sports participation, to be referred to when the physician examines a young person with one of the listed conditions. Our recommendations should only be used as a guideline.