ATHLETIC PRE-PARTICIPATION
PHYSICAL EXAMINATION

Every year each student (grades 7-12) shall present this form to the school's athletic director *signed by a licensed physician, 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 and transportation.

This certificate of physical examination is valid 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)

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.)***

	Yes	No	Has this student had any?
1.	_____	_____	Chronic or recurrent illness or injury?
2.	_____	_____	Any illness lasting more than one (1) week?
3.	_____	_____	Rheumatic fever, mononucleosis?
4.	_____	_____	Hospitalizations (Overnight or longer)?
5.	_____	_____	Surgery, other than tonsillectomy?
6.	_____	_____	Missing organs (eye, kidney, testicle)?
7.	_____	_____	Allergy to medications, insects, food?
8.	_____	_____	Seasonal allergies (hay fever)?
9.	_____	_____	Problems with heart, blood pressure, cholesterol?
10.	_____	_____	Racing of your heart or skipped heart beats?
11.	_____	_____	Chest pain with exercise?
12.	_____	_____	Frequent headaches, convulsions, dizziness, fainting?
13.	_____	_____	Dizziness or fainting with exercise?
14.	_____	_____	Concussion, unconsciousness, extremity numbness?
15.	_____	_____	Heat exhaustion, heat stroke, or other heat related problems?

	Yes	No	Has this student had any?
16.	_____	_____	Asthma?
17.	_____	_____	Epilepsy or other seizures?
18.	_____	_____	Diabetes?
19.	_____	_____	Eyeglasses or contact lenses?
20.	_____	_____	Dental braces, bridges, plates?

	Yes	No	Has this student had any?
21.	_____	_____	Injuries requiring medical treatment?
22.	_____	_____	Neck injury?
23.	_____	_____	Knee injury?
24.	_____	_____	Knee surgery?
25.	_____	_____	Ankle injury?
26.	_____	_____	Broken bones (fractures)?
27.	_____	_____	Other serious joint injuries?
28.	_____	_____	Use of protective equipment or braces?

	Yes	No	Has this student had any?
29.	_____	_____	Is there a history of family or genetic disease?
30.	_____	_____	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
31.	_____	_____	Has any family member had a heart attack at less than 55 years of age?
32.	_____	_____	Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping?

***Use this space to explain any of the above numbered** YES answers or to provide additional information:*

_____

_____

_____

33. List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A. _____ B. _____ C. _____

34. Year of last known: Tetanus (lockjaw) vaccination: _____ Meningitis vaccination: _____ HBV vaccination: _____

35. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least*** _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated above). ***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 _____/_____ Vision R 20/_____ L 20/_____ Vision corrected? Yes_____ No_____

	Normal	Abnormal Findings	Initials
Appearance (esp. Marfan's)			
Eyes / Ears / Nose / Throat			
Mouth & Teeth			
Neck			
Lymph Nodes			
Heart (Standing & Lying)			
Pulses (esp. femoral)			
Chest & Lungs			
Abdomen			
Skin			
Genitals – Hernia			
Musculoskeletal – **ROM, strength, etc (see questions 21-28)**			
Neurological			

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

_____ _____
Licensed Medical Professional's Name *(Printed)* **Date**

_____ _____
Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION

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.

ACCIDENT INSURANCE IS REQUESTED for all students participating in athletics.

PARENT'S OR GUARDIAN'S ELECTION & RELEASE

☐ We have our own coverage and we ***RELEASE*** the school from all financial liability resulting from accidental injury while participating in interscholastic athletics.

☐ We do NOT have insurance and have been provided information about Hawk-I / CHIP Insurance provided to families at a low cost when income guidelines are met. We declined and ***RELEASE*** the school from all financial liability resulting from accidental injury while participating in interscholastic athletics.

Company Name: _____ Policy #: _____

_____ _____
Typed or printed Name of Parent or Guardian Signature of Parent of Guardian

_____ _____
Address (Street/PO Box, City, State, Zip) Phone Number

(***Form # 376 – Revised 2014)***
(Reviewed 2017/2018)

Hawk-I / CHIP Application Process and Information

To apply online, please visit the Iowa Department of Human Services and click on "Apply for benefits".

For additional application information, visit the hawk-i 'How to apply' page. You will be able to download an application form directly from the site.

You may also find out if you qualify through the Marketplace application.

Program Contact Information

To learn more about the program, please visit the hawk-i - Healthy and Well Kids in Iowa page.

For additional details, please visit the Medicaid & CHIP Policies page and select “IOWA”.

The Healthy and Well Kids in Iowa (hawk-i), federally known as Children's Health Insurance Program (CHIP), provides health coverage to nearly eight million children and families with incomes too high to qualify for Medicaid, but can't afford private coverage.

In some states, CHIP covers parents and pregnant women. Each state offers CHIP coverage, and works closely with its state Medicaid program. Please note: These programs may be called by different names in your state.

Some benefits covered through CHIP, include:

- Routine check-ups
- Immunizations
- Doctor visits
- Prescriptions
- Dental and vision care
- Inpatient and outpatient hospital care
- Laboratory and X-ray services
- Emergency services

CHIP serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid.

In general for this benefit program, the child must be a U.S. national, citizen, legal alien or permanent resident, and have low income.

The child must also be a resident of Iowa.

In order to qualify, you must have an annual household income (before taxes) that is below the following amounts:

Household Size*	Maximum Income Level (Per Year)
1	$35,640
2	$48,060
3	$60,480
4	$72,900
5	$85,320
6	$97,740
7	$110,190
8	$122,670

***For households with more than eight people, add** $12,480 **per additional person. Always check with the appropriate managing agency to ensure the most accurate guidelines.**