

KENTUCKY HIGH SCHOOL ATHLETIC ASSOCIATION
 2280 Executive Drive, Lexington, Kentucky 40505
 Athletic Participation/Parental Consent/Physical Examination Form

PART I - ATHLETE INFORMATION

(To be completed by athlete)

Name: _____ School Year _____
 (Last) (First) (Initial)

Home Address: _____
 (Street) (City, State, zip)

Date of Birth: _____ Birth Place (County, State): _____

This is my _____ year at _____ School and my
 _____ year since entering ninth grade. Last year I attended _____

School. I am planning to participate in the following (circle all you might try to play):

- Baseball Cross Country Golf Softball Tennis Volleyball
 Basketball Football Soccer Swimming Track Wrestling
 Cheerleading Field Hockey Other:

PART II - MEDICAL HISTORY

This form must be completed by parent and athlete prior to the time of the physical exam and presented to the authorized health care provider before the physical.

CHECK THE APPROPRIATE RESPONSE TO EACH ITEM:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery of any kind (e.g., tonsillectomy). | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, or other insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems before 50?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems? (itching, rashes, acne) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure or suffer from epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat related problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough heavily, or breath heavily during activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (e.g., knee brace)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you missing one of any paired organs (e.g., eyes) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever been diagnosed with any form of asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you using an inhaler for asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you administer insulin to yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you presently using tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have a history of sickle-cell anemia in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had any other medical problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had a medical problem or injury within the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Can you swim? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. When was your last tetanus shot? _____ | | |

Please explain any YES answers from questions 1-18. _____

PART III - PHYSICAL EXAMINATION

NAME: _____ SEX _____
 SCHOOL: _____ GRADE _____
 HEIGHT: _____ WEIGHT _____ BP _____ / _____ PULSE _____
 VISION: R- 20/ _____ L- 20/ _____ BOTH- 20/ _____ CORRECTED? Y N

	Normal	Abnormal	Comment
HEART			
Rhythm (Regular/Irregular)			
Murmur (supine)			
Murmur (standing)			
ENT			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Dental			
Other			

I have reviewed the data above, reviewed the student's medical history and make the following recommendations on participation in athletics:

1. Cleared _____
 2. Cleared after additional evaluation for _____
 3. Restricted from participating in the sports of _____
 4. Cleared to participate in the sports of _____
- Recommendations/Restriction _____

In accordance with KHSAA Bylaws, I have examined the physical condition of the student and find the said pupil to be physically fit to practice for and participate in interscholastic athletic contests.

Authorized Signature _____ Date _____

Authorized Provider's Name (please print) _____

Address _____ Phone _____

Date _____ City, State, Zip _____

