



**Nebraska School Activities Association  
School Sports Qualifying Screening Evaluation**

**Please Complete in Ink**

*INSTRUCTIONS FOR COMPLETING THE PRE-PARTICIPATION FORM*

**REASONS FOR RECOMMENDED CHANGES IN PRE-PARTICIPATION PHYSICAL FORMS**

The NSAA's Sports Medicine Advisory Committee has recommended that schools utilize a different form and different procedures than have previously been used for activities pre-participation physical examinations. Medical professionals on the NSAA Sports Medicine Advisory Committee expressed concerns that some of the processes of collection of and access to confidential student medical information for athletic participation purposes would likely constitute an infringement of privacy.

In the past, the two-part NSAA pre-participation physical form included (1) a page of student medical history, and (2) a page with the actual examination report. Once the physical examination was completed, both the medical history and examination report were filed with the student's high school, often by the physician or medical clinic—a practice that has been challenged as infringing on privacy.

The attached form is a product of and used with the approval of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

This proposed three-part form includes (1) a History Form; (2) the actual Physical Examination Form; and (3) the Clearance Form. It is anticipated that the examining physician would retain on file the History Form and the Physical Examination Form, with only the Clearance Form being returned to the student to be placed on file in the school office.

**SCHOOL ENTRY PHYSICAL EXAMINATIONS**

This physical examination form and procedures is intended for pre-participation athletic physicals. In the past, some schools have utilized the NSAA physical form for school-entry physicals. This form could be used for that purpose, as well, but it is important to note that there may be important components of the school-entry physical examination requirements that are not included on this form (e.g., vision examination).

**SIGNATURE(S)**

For the form to be valid, it must be signed by a physician or medical person within the scope of his/her training and within the limits defined by state statutes as to services which can be legally performed by the field of practice to which the individual belongs.

**PARENTAL CONSENT FORM**

The Parental Consent Form is a form based on current language making sure parents and athletes understand completely there are risks with any athletic activity. This form is very "generic" and can be easily modified to fit the individual school. Since some schools may want to be very specific in their forms, this form may be modified. It is currently designed to refer to a school's specific sets of policies, rules and regulations for athletic participation. The Parental Consent Form should be placed on file for every student who participates in NSAA activities, athletic and non-athletic.

# Preparticipation Physical Evaluation

**HISTORY  
FORM**

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

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

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

- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
|--|------------|-----------|
1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No
  2. Do you have an ongoing medical condition (like diabetes or asthma)?  Yes  No
  3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  Yes  No
  4. Do you have allergies to medicines, pollens, foods, or stinging insects?  Yes  No
  5. Have you ever passed out or nearly passed out DURING exercise?  Yes  No
  6. Have you ever passed out or nearly passed out AFTER exercise?  Yes  No
  7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  Yes  No
  8. Does your heart race or skip beats during exercise?  Yes  No
  9. Has a doctor ever told you that you have (check all that apply):
 

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> A heart murmur
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> A heart infection
  10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)  Yes  No
  11. Has anyone in your family died for no apparent reason?  Yes  No
  12. Does anyone in your family have a heart problem?  Yes  No
  13. Has any family member or relative died of heart problems or of sudden death before age 50?  Yes  No
  14. Does anyone in your family have Marfan syndrome?  Yes  No
  15. Have you ever spent the night in a hospital?  Yes  No
  16. Have you ever had surgery?  Yes  No
  17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:  Yes  No
  18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:  Yes  No
  19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:  Yes  No

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?  Yes  No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  Yes  No
22. Do you regularly use a brace or assistive device?  Yes  No
23. Has a doctor ever told you that you have asthma or allergies?  Yes  No

- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
|--|------------|-----------|
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes  No
  25. Is there anyone in your family who has asthma?  Yes  No
  26. Have you ever used an inhaler or taken asthma medicine?  Yes  No
  27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  Yes  No
  28. Have you had infectious mononucleosis (mono) within the last month?  Yes  No
  29. Do you have any rashes, pressure sores, or other skin problems?  Yes  No
  30. Have you had a herpes skin infection?  Yes  No
  31. Have you ever had a head injury or concussion?  Yes  No
  32. Have you been hit in the head and been confused or lost your memory?  Yes  No
  33. Have you ever had a seizure?  Yes  No
  34. Do you have headaches with exercise?  Yes  No
  35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes  No
  36. Have you ever been unable to move your arms or legs after being hit or falling?  Yes  No
  37. When exercising in the heat, do you have severe muscle cramps or become ill?  Yes  No
  38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?  Yes  No
  39. Have you had any problems with your eyes or vision?  Yes  No
  40. Do you wear glasses or contact lenses?  Yes  No
  41. Do you wear protective eyewear, such as goggles or a face shield?  Yes  No
  42. Are you happy with your weight?  Yes  No
  43. Are you trying to gain or lose weight?  Yes  No
  44. Has anyone recommended you change your weight or eating habits?  Yes  No
  45. Do you limit or carefully control what you eat?  Yes  No
  46. Do you have any concerns that you would like to discuss with a doctor?  Yes  No

- FEMALES ONLY**
47. Have you ever had a menstrual period?  Yes  No
  48. How old were you when you had your first menstrual period? \_\_\_\_\_
  49. How many periods have you had 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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**I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.**

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

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

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

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

### Follow-Up Questions on More Sensitive Issues

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc | <input type="checkbox"/> | <input type="checkbox"/> |

Notes:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary†			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.

†Having a third party present is recommended for the genitourinary examination.

Notes:

\_\_\_\_\_  
 \_\_\_\_\_

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

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

Signature of physician \_\_\_\_\_, MD or DO

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ B/P \_\_\_\_\_

Cleared without restriction

Diagnosis of Asthma? Yes \_\_\_ No \_\_\_ (If yes, please attach copy of Asthma Action Plan. \*Must have Dr.'s signature.)

*\*\*\*All students with a diagnosis of asthma must have an AAP on file with the school nurse.*

Allergies: \_\_\_\_\_

Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_

Not cleared for     All Sports     Certain Sports \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of Physician \_\_\_\_\_