COPY this Clearance Form for the student to return to the school. KEEP the complete document in the student's medical record.

2019-2020 SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM

Minnesota State High School League

Student Name:_____ Birth Date: _____ Age:____ Gender: M / F
Address:_____
Home Telephone: _____ - _____ - _____ Mobile Telephone _____ - _____ - _____
School: _____ Grade: ____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check Only One Box)

☐ **(1) Participate in all school interscholastic activities without restrictions.**
☐ **(2) Participate in any activity not crossed out below.**

Sport Classification Based on Contact

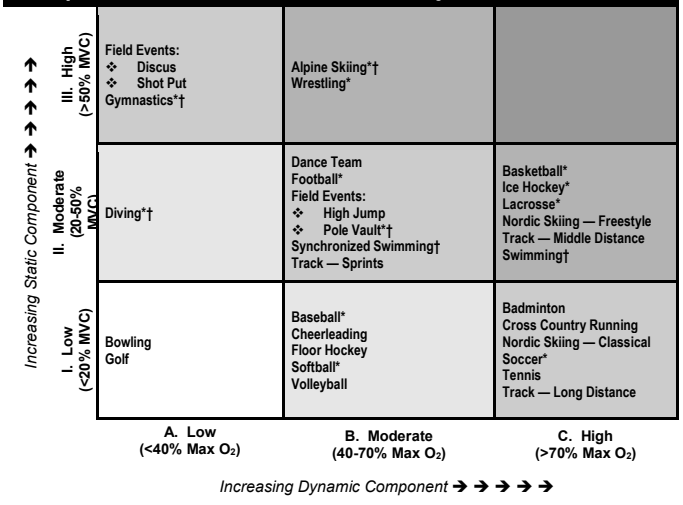
Collision Contact Sports	Limited Contact Sports	Non-contact Sports
Basketball Cheerleading Diving Football Gymnastics Ice Hockey Lacrosse Alpine Skiing Soccer Wrestling	Baseball Field Events: ❖ High Jump ❖ Pole Vault Floor Hockey Nordic Skiing Softball Volleyball	Badminton Bowling Cross Country Running Dance Team Field Events: ❖ Discus ❖ Shot Put Golf Swimming Tennis Track

☐ **(3) Requires further evaluation before a final recommendation can be made.**
Additional recommendations for the school or parents**:**

_____
_____

☐ **(4) Not cleared for:** ☐ **All Sports**
☐ **Specific Sports**_____
_____
Reason:_____
_____

Sport Classification Based on Intensity & Strenuousness



Sport Classification Based on Intensity & Strenuousness: This classification is based on peak static and dynamic components achieved during competition. It should be noted, however, that higher values may be reached during training. The increasing dynamic component is defined in terms of the estimated percent of maximal oxygen uptake ($MaxO_2$) achieved and results in an increasing cardiac output. The increasing static component is related to the estimated percent of maximal voluntary contraction (MVC) reached and results in an increasing blood pressure load. The lowest total cardiovascular demands (cardiac output and blood pressure) are shown in lightest shading and the highest in darkest shading. The graduated shading in between depicts low moderate, moderate, and high moderate total cardiovascular demands. *Danger of bodily collision. †Increased risk if syncope occurs. Reprinted with permission from: Maron BJ, Zipes DP. 36th Bethesda Conference: eligibility recommendations for competitive athletes with cardiovascular abnormalities. *J Am Coll Cardiol.* 2005; 45(8):1317–1375.

I have examined the above named student and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents.

Attending Provider Signature _____ Date of Exam_____
Print Provider Name: _____
Office/Clinic Name _____ Address: _____
City, State, Zip Code _____
Office Telephone: _____ - _____ - _____ E-Mail Address: _____

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 1-2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual)]

☐ Up-to-date (see attached school documentation) ☐ Not reviewed at this visit
IMMUNIZATIONS GIVEN TODAY:_____

EMERGENCY INFORMATION
Allergies _____
Other Information_____
Emergency Contact:_____ Relationship _____
Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____
Personal Provider_____ Office Telephone _____ - _____ - _____

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.
FOR SCHOOL ADMINISTRATION USE: ☐ [Year 2 Normal] ☐ [Year 3 Normal]

Reference: Preparticipation Physical Evaluation (4th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2010.

2019-2020 SPORTS QUALIFYING PHYSICAL HISTORY FORM

Minnesota State High School League

Student Name:_____ Birth Date: _____ Date of Exam:_____

History

Circle Question Number (1.) of questions for which the answer is unknown. Circle Y for Yes or N for No

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? Y / N
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infections)? Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y / N
   List:_____
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y / N
5. Have you ever spent the night in a hospital? Y / N
6. Have you ever had surgery? Y / N

HEART HEALTH QUESTIONS ABOUT YOU

7. Have you ever passed out or nearly passed out DURING exercise? Y / N
8. Have you ever passed out or nearly passed out AFTER exercise? Y / N
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y / N
10. Does your heart race or skip beats (irregular beats) during exercise? Y / N
11. Has a doctor ever told you that you have? (circle):
    High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever Kawasaki's Disease
12. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test) Y / N
13. Do you get lightheaded or feel more short of breath than expected during exercise? Y / N
14. Have you ever had an unexplained seizure? Y / N
15. Do you get more tired or short of breath more quickly than your friends during exercise? Y / N

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

16. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning or unexplained car accident)? Y / N
17. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Y / N
18. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?. Y / N
19. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Y / N

BONE AND JOINT QUESTIONS

20. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? Y / N
21. Have you had any broken or fractured bones or dislocated joints? Y / N
22. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Y / N
23. Have you ever had a stress fracture? Y / N
24. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Y / N
25. Do you regularly use a brace, orthotics or other assistive device? Y / N
26. Do you have a bone, muscle, or joint injury that bothers you? Y / N
27. Do any of your joints become painful, swollen, feel warm, or look red? Y / N
28. Do you have any history of juvenile arthritis or connective tissue disease? Y / N

MEDICAL QUESTIONS

29. Has a doctor ever told you that you have asthma or allergies? Y / N
30. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise? Y / N
31. Is there anyone in your family who has asthma? Y / N
32. Have you ever used an inhaler or taken asthma medicine? Y / N
33. Do you develop a rash or hives when you exercise? Y / N
34. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ? Y / N
35. Do you have groin pain or a painful bulge or hernia in the groin area? Y / N
36. Have you had infectious mononucleosis (mono) within the last month? Y / N
37. Do you have any rashes, pressure sores, or other skin problems? Y / N
38. Have you had a herpes or MRSA skin infection? Y / N
39. Have you ever had a head injury or concussion? Y / N
40. Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems? Y / N
41. Do you have a history of seizure disorder? Y / N
42. Do you have headaches with exercise? Y / N
43. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y / N
44. Have you ever been unable to move your arms or legs after being hit or falling? Y / N
45. Have you ever become ill while exercising in the heat? Y / N
46. Do you get frequent muscle cramps when exercising? Y / N
47. Do you or someone in your family have sickle cell trait or disease? Y / N
48. Have you had any problems with your eyes or vision? Y / N
49. Have you had any eye injuries? Y / N
50. Do you wear glasses or contact lenses? Y / N
51. Do you wear protective eyewear, such as goggles or a face shield? Y / N
52. Do you worry about your weight? Y / N
53. Are you trying to or has anyone recommended that you gain or lose weight? Y / N
54. Are you on a special diet or do you avoid certain types of foods? Y / N
55. Have you ever had an eating disorder? Y / N
56. Do you have any concerns that you would like to discuss with a doctor? Y / N

FEMALES ONLY

57. Have you ever had a menstrual period? Y / N
58. How old were you when you had your first menstrual period? _____
59. How many menstrual periods have you had in the last year? _____

Notes: _____

_____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

_____ _____ _____

Parent or Legal Guardian Signature Student-Athlete Signature Date

	Age if Living	Age At Death	Cause of Death or Main Medical Problem
Father			
Mother			
Brothers			
Sisters			

Please Circle Illnesses which have occurred in any of your blood relatives:

Diabetes	Cancer	Suicide	Kidney Disease	Tuberculosis	Ulcers
Chemical	Stroke	High Blood	Allergy	Nervous Illness	Gallbladder
Dependency		Pressure			Disease

Please Circle Illnesses or conditions you have had:

Glaucoma	Venereal	Vein trouble	Cancer	Nervous
Arthritis	Disease	Blood	Tuberculosis	Disorder
Other:	Pneumonia	Transfusions		Kidney
				Disease

Do you use tobacco now? ___ In the Past? ___ Type and daily amount?_____ How Long?_____

Do you use alcoholic beverages? ___ Type? _____ Weekly amount? _____ How Long? _____

Do you use street drugs? ___ Type? _____ How often? _____ How Long? _____

Are you sexually active? ____ Yes ____ No

Do you feel stressed out or under a lot of pressure? ____ Yes ____ No

Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? ____ Yes ____ No

Do you feel safe? ____ Yes ____ No

Have you ever taken steroid pills or shots without a doctor's prescription? ____ Yes ____ No

Have you ever taken any supplements to help you gain or lose weight or improve your performance? ____ Yes ____ No

Please circle any problems:

General:	Weakness	Fever	Night Sweats	Chills	Weight Loss
	Loss of Energy	Skin Problems			
Breasts:	Discharge	Masses			
Urinary:	Pain on Urination	Night Urination	Burning	Lack of Control	
Extremities and Spine:	Pain	Cold	Strength	Arthritis	Varicose Veins
	Back Pain				
Reproductive/ Endocrine:	Thyroid				
Psychiatric:	Counselor or psychiatrist seen	Family problems	Depression	Unable to Sleep	