

COPY Medical Eligibility 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 MEDICAL ELIGIBILITY FORM
Minnesota State High School League

Student Name: Birth Date:
Address:
Home Telephone: Mobile Telephone
School:

I certify that the above student has been medically evaluated and is deemed medically eligible to: (Check Only One Box)
(1) Participate in all school interscholastic activities without restrictions.
(2) Participate in any activity not crossed out below.

Table: Sport Classification Based on Contact. Columns: Collision Contact Sports, Limited Contact Sports, Non-contact Sports. Lists various sports like Basketball, Baseball, Badminton, etc.

Table: Sport Classification Based on Intensity & Strenuousness. Grid with rows for Static Component (High, Moderate, Low) and columns for Dynamic Component (A. Low, B. Moderate, C. High). Lists sports like Field Events, Alpine Skiing, etc.

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

(4) Not medically eligible for: All Sports / Specific Sports. Specify

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...

I have examined the student named on this form and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. The athlete does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form...

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, 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]

# 2019-2020 SPORTS QUALIFYING PHYSICAL HISTORY FORM

## Minnesota State High School League

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

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

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

Past and current medical conditions: \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgeries. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

### Patient Health Questionnaire Version 4 (PHQ-4)

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(If the sum of responses to questions 1 & 2 or 3 & 4 are >or = 3, evaluate.)

Circle Question Number (1) of questions for which the answer is unknown.

Circle Y for Yes or N for No

#### GENERAL QUESTIONS

- 1. Do you have any concerns that you would like to discuss with your provider? ..... Y / N
- 2. Has a provider ever denied or restricted your participation in sports for any reason? ..... Y / N
- 3. Do you have any ongoing medical issues or recent illness? ..... Y / N

#### HEART HEALTH QUESTIONS ABOUT YOU\*

- 4. Have you ever passed out or nearly passed out during or after exercise? ..... Y / N
- 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ..... Y / N
- 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? ..... Y / N
- 7. Has a doctor ever told you that you have any heart problems? ..... Y / N
- 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. .... Y / N
- 9. Do you get light-headed or feel shorter of breath than your friends during exercise? ..... Y / N
- 10. Have you ever had a seizure? ..... Y / N

#### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY\*

- 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? ..... Y / N
- 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? ..... Y / N
- 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? ..... Y / N

#### BONE AND JOINT QUESTIONS

- 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? ..... Y / N
- 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? ..... Y / N

#### MEDICAL QUESTIONS

- 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? ..... Y / N
- 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? ..... Y / N
- 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? ..... Y / N
- 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? .. Y / N
- 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? ..... Y / N
- 21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? ..... Y / N
- 22. Have you ever become ill while exercising in the heat? ..... Y / N
- 23. Do you or does someone in your family have sickle cell trait or disease? ..... Y / N
- 24. Have you ever had, or do you have any problems with your eyes or vision? ..... Y / N
- 25. Do you worry about your weight? ..... Y / N
- 26. Are you trying to or has anyone recommended that you gain or lose weight? ..... Y / N
- 27. Are you on a special diet or do you avoid certain types of foods or food groups? ..... Y / N
- 28. Have you ever had an eating disorder? ..... Y / N

#### FEMALES ONLY

- 29. Have you ever had a menstrual period? ..... Y / N
- 30. How old were you when you had your first menstrual period? \_\_\_\_\_
- 31. When was your most recent menstrual period? \_\_\_\_\_
- 32. How many periods have you had in the past 12 months? \_\_\_\_\_

Notes: \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 2019-2020 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM

### Minnesota State High School League

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Follow-Up Questions About More Sensitive Issues:**

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette, cigar, pipe, e-cigarette smoking, or vaping, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had any alcohol drinks, even just one?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
9. Question "Risk Behaviors" like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

**Notes About Follow-Up Questions:**

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

### MEDICAL EXAM

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI (optional) \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Arm Span \_\_\_\_\_  
 Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y / N Contacts: Y / N Hearing: R \_\_\_\_\_ L \_\_\_\_\_ (Audiogram or confrontation)

Exam	Normal	Abnormal Findings	Initials*
<b>Appearance</b>			
Circle any Marfan stigmata present	→	Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency	
<b>HEENT</b>			
Eyes			
Fundoscopy			
Pupils			
Hearing			
<b>Cardiovascular<sup>a</sup></b>			
Describe any murmurs present (standing, supine, +/- Valsalva)	→		
Pulses (simultaneous femoral & radial)			
<b>Lungs</b>			
<b>Abdomen</b>			
<b>Tanner Staging (optional)</b>	Circle	I II III IV V	
<b>Skin (No HSV, MRSA, Tinea corporis)</b>			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional (Double-leg squat test, single-leg squat test, and box drop or step drop test)			

<sup>a</sup> Consider ECG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings \* For Multiple Examiners

Additional Notes: \_\_\_\_\_  
 \_\_\_\_\_

Health Maintenance:  Lifestyle, health, immunizations, & safety counseling     Discussed dental care & mouthguard use  
 Discussed Lead and TB exposure – (Testing indicated / not indicated)     Eye Refraction if indicated

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ATHLETE WITH DISABILITIES SUPPLEMENT TO THE ATHLETE HISTORY

## Minnesota State High School League

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

- 1. Type of disability:
- 2. Date of disability:
- 3. Classification (if available):
- 4. Cause of disability (birth, disease, injury, or other):
- 5. List the sports you are playing:
- 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? Y / N
- 7. Do you use any special brace or assistive device for sports? Y / N
- 8. Do you have any rashes, pressure sores, or other skin problems? Y / N
- 9. Do you have a hearing loss? Do you use a hearing aid? Y / N
- 10. Do you have a visual impairment? Y / N
- 11. Do you use any special devices for bowel or bladder function? Y / N
- 12. Do you have burning or discomfort when urinating? Y / N
- 13. Have you had autonomic dysreflexia? Y / N
- 14. Have you ever been diagnosed as having a heat-related or cold-related illness? Y / N
- 15. Do you have muscle spasticity? Y / N
- 16. Do you have frequent seizures that cannot be controlled by medication? Y / N

**Explain "Yes" answers here.**

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**Please indicate whether you have ever had any of the following conditions:**

- Atlantoaxial instability Y / N
- Radiographic (x-ray) evaluation for atlantoaxial instability Y / N
- Dislocated joints (more than one) Y / N
- Easy bleeding Y / N
- Enlarged spleen Y / N
- Hepatitis Y / N
- Osteopenia or osteoporosis Y / N
- Difficulty controlling bowel Y / N
- Difficulty controlling bladder Y / N
- Numbness or tingling in arms or hands Y / N
- Numbness or tingling in legs or feet Y / N
- Weakness in arms or hands Y / N
- Weakness in legs or feet Y / N
- Recent change in coordination Y / N
- Recent change in ability to walk Y / N
- Spina bifida Y / N
- Latex allergy Y / N

**Explain "Yes" answers here.**

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_ Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# 2019-2020 PI ADAPTED ATHLETICS MEDICAL ELIGIBILITY FORM ADDENDUM Minnesota State High School League

(Use only for Adapted Athletics - PI Division)

The MSHSL has competitive interscholastic Physically Impaired (PI) competition. Students who are deemed fit to participate in competitive athletics from a MSHSL sports qualifying exam should meet the criteria below to participate in Adapted Athletics – PI Division.

The MSHSL Adapted Athletics PI Division program is specifically intended for students with physical impairments who have medically eligible to compete in competitive athletics. A student is administratively eligible to compete in the PI Division with one of the two following criteria:

The student must have a diagnosed and documented impairment specified from one of the two sections below: *(Must be diagnosed and documented by a Physician, Physician's Assistant, and/or Advanced Practice Nurse.)*

- 1. \_\_\_\_\_ Neuromuscular                      \_\_\_\_\_ Postural/Skeletal                      \_\_\_\_\_ Traumatic  
       \_\_\_\_\_ Growth                                      \_\_\_\_\_ Neurological Impairment

Which: \_\_\_\_\_ affects Motor Function                      \_\_\_\_\_ modifies Gait Patterns

(Optional) \_\_\_\_\_ Requires the use of prosthesis or mobility device, including but not limited to canes, crutches, walker or wheelchair.

- 2. \_\_\_\_\_ Cardio/Respiratory Impairment that is deemed safe for competitive athletics, but limits the intensity and duration of physical exertion such that sustained activity for over five minutes at 60% of maximum heart rate for age results in physical distress in spite of appropriate management of the health condition.

**(NOTE:)** A condition that can be appropriately managed with appropriate medications that eliminate physical or health endurance limitations **WILL NOT** be considered eligible for adapted athletics.

**Specific exclusions to PI competition:**

The following health conditions, without coexisting physical impairments as outlined above, do not qualify the student to participate in the PI Division even though some of the conditions below may be considered Health Impairments by an individual's physician, a student's school, or government agency. This list is not all-inclusive, and the conditions are examples of non-qualifying health conditions; other health conditions that are not listed below may also be non-qualifying for participation in the PI Division.

Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Emotional Behavioral Disorder (EBD), Autism spectrum disorders (including Asperger's Syndrome), Tourette's Syndrome, Neurofibromatosis, Asthma, Reactive Airway Disease (RAD), Bronchopulmonary Dysplasia (BPD), Blindness, Deafness, Obesity, Depression, Generalized Anxiety Disorder, Seizure Disorder, or other similar disorders.

Student Name \_\_\_\_\_

Provider (PRINT) \_\_\_\_\_

Provider (SIGNATURE) \_\_\_\_\_

Date of Exam \_\_\_\_\_