

## INSURANCE STATEMENT

It is the policy of Decorah Community Schools that students participating in interscholastic athletics be covered by a private student accident insurance plan OR sign the statement below stating they do not wish to purchase coverage.

(The school district is not forcing anyone to purchase insurance but only to sign a statement that they are aware of the student accident insurance plan offering).

\_\_\_\_\_ I do                      \_\_\_\_\_ I do not

wish to have \_\_\_\_\_ insured under  
(Student's name)  
the student accident plan offered by the school.

\_\_\_\_\_  
Date                                      Parent Signature

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## ACKNOWLEDGEMENT OF RISK

We realize there is a possibility that a player may suffer severe injury, including permanent paralysis or death, as a result of participating in athletic activities.

\_\_\_\_\_  
Student's Name (PRINT)                      Parent/Guardian Name (PRINT)

\_\_\_\_\_  
Student's Signature                              Parent/Guardian Signature

\_\_\_\_\_  
Date    School Name



## DECORAH COMMUNITY SCHOOLS

### ATHLETIC PHYSICAL & ELIGIBILITY FORM

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

\_\_\_\_\_  
Grade                      School Year

#### Directions for completion:

1. Parent and student fill out pages 1, 2, & 4 and sign where designated.
2. Schedule an appointment to enable a licensed professional to complete the top section of page 3.
3. Parent must sign the bottom of page 3 after the physical is complete from the licensed professional.

**To have full eligibility, all sections of this form  
and all signatures must be completed.**

**IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION**

**ARTICLE VII 36.14(1) PHYSICAL EXAMINATION.** Every year each student (grades 7-12) shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition. This certificate of physical examination is valid for the purpose of this rule 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).**

Student's Name \_\_\_\_\_ Male  Female  Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
 Home Address (Street, City, Zip) \_\_\_\_\_ School District \_\_\_\_\_  
 Parent's/Guardian's Name \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Date \_\_\_\_\_ 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 after the examination).

Yes	No	Does this student have/ever had?	Yes	No	Does this student have/ever had?
1	<input type="checkbox"/>	Allergies to medication, pollen, stinging insects, food, etc.?	20	<input type="checkbox"/>	Head injury, concussion, unconsciousness?
2	<input type="checkbox"/>	Any illness lasting more than one (1) week?	21	<input type="checkbox"/>	Headache, memory loss, or confusion with contact?
3	<input type="checkbox"/>	Asthma or difficulty breathing during exercise?	22	<input type="checkbox"/>	Numbness, tingling or weakness in arms or legs with contact?
4	<input type="checkbox"/>	Chronic or recurrent illness or injury?	23	<input type="checkbox"/>	Severe muscle cramps or illness when exercising in the heat?
5	<input type="checkbox"/>	Diabetes?	24	<input type="checkbox"/>	Fracture, stress fracture or dislocated joint(s)?
6	<input type="checkbox"/>	Epilepsy or other seizures?	25	<input type="checkbox"/>	Injuries requiring medical treatment?
7	<input type="checkbox"/>	Eyeglasses or contacts?	26	<input type="checkbox"/>	Knee injury or surgery?
8	<input type="checkbox"/>	Herpes or MRSA?	27	<input type="checkbox"/>	Neck injury?
9	<input type="checkbox"/>	Hospitalizations (overnight or longer)?	28	<input type="checkbox"/>	Orthotics, braces, protective equipment?
10	<input type="checkbox"/>	Marfan Syndrome?	29	<input type="checkbox"/>	Other serious joint injury?
11	<input type="checkbox"/>	Missing organ (eye, kidney, testicle)?	30	<input type="checkbox"/>	Painful bulge or hernia in the groin area?
12	<input type="checkbox"/>	Mononucleosis or Rheumatic Fever?	31	<input type="checkbox"/>	X-rays, MRI, CT scan, physical therapy?
13	<input type="checkbox"/>	Seizures or frequent headaches?	32	<input type="checkbox"/>	Has a doctor ever denied or restricted your participation in sports for any reason?
14	<input type="checkbox"/>	Surgery?	33	<input type="checkbox"/>	Do you have any concerns you would like to discuss with your health care provider?
15	<input type="checkbox"/>	Chest pressure, pain, or tightness with exercise?			
16	<input type="checkbox"/>	Excessive shortness of breath with exercise?			
17	<input type="checkbox"/>	Headaches, dizziness or fainting during or after exercise?			
18	<input type="checkbox"/>	Heart problems (racing, skipped beats, murmur, infection, etc.)?			
19	<input type="checkbox"/>	High blood pressure or high cholesterol?			

**FAMILY HISTORY:**

Yes	No	FAMILY HISTORY:
34	<input type="checkbox"/>	Does anyone in your family have Marfan syndrome?
35	<input type="checkbox"/>	Has anyone in your family dies of heart problems or any unexpected/unexplained reason before the age of 50?
36	<input type="checkbox"/>	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37	<input type="checkbox"/>	Has anyone in your family had unexplained fainting, seizures, or near drowning?
38	<input type="checkbox"/>	Does anyone in your family have asthma?
39	<input type="checkbox"/>	Do you or someone in your family have sickle cell trait or disease?

Use this space to explain any "YES" answers from above (questions #1-38) or to provide any additional information:

40 Are you allergic to any prescription or over-the-counter medications? If yes, list: \_\_\_\_\_

41 List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:  
 A \_\_\_\_\_ B \_\_\_\_\_ C \_\_\_\_\_

42 Year of last known vaccination: Tdap (Tetanus): \_\_\_\_\_ Meningitis: \_\_\_\_\_ Influenza: \_\_\_\_\_

43 What is the most and least you have weighed in the past year? Most \_\_\_\_\_ Least \_\_\_\_\_

44 Are you happy with your current weight? Yes  No  If no, how many pounds would like to lose or gain? Lose \_\_\_\_\_ Gain \_\_\_\_\_

**FOR FEMALES ONLY:**

1. How old were you when you had your first menstrual period? \_\_\_\_\_ 2. How many periods have you had in the last 12 months? \_\_\_\_\_

Page 1 of 2, Physical Examination Record & Parent's/Guardian's Permission and Release is on the reverse side.

**PHYSICAL EXAMINATION RECORD:**

(to be completed by a licensed medical professional as designated in Article VII 36.14(1).

Athlete Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Pulse: \_\_\_\_\_ Blood pressure: \_\_\_\_\_ / \_\_\_\_\_ (repeat, if abnormal \_\_\_\_\_ / \_\_\_\_\_) Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
1 Appearance (esp. Marfans)			
2 Eyes/Ears/Nose/Throat			
3 Pupil Size (Equal/Unequal)			
4 Mouth & Teeth			
5 Neck			
6 Lymph Nodes			
7 Heart (Standing & Lying)			
8 Pulses (esp. femoral)			
9 Chest & Lungs			
10 Abdomen			
11 Skin			
12 Genitals - Hernia			
13 Musculoskeletal - ROM, Strength, etc. (See questions 24-31)			
14 Neurological			

Comments regarding abnormal findings: \_\_\_\_\_

**LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS**  
 (Please be precise when indicating at which level the student is cleared to participate.)

- 1  **FULL & UNLIMITED PARTICIPATION**
- 2  **LIMITED PARTICIPATION** - May NOT participate in the following (checked):  
 Baseball  Basketball  Bowling  Cross Country  Football  Golf  Soccer  
 Softball  Swimming  Tennis  Track  Volleyball  Wrestling
- 3  **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** \_\_\_\_\_
- 4  **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** \_\_\_\_\_

Licensed Medical Professional's Name (Printed) \_\_\_\_\_ Date of PPE \_\_\_\_\_  
 Licensed Medical Professional's Signature \_\_\_\_\_ Phone \_\_\_\_\_

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I hereby verify the accuracy of 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/illness and to share necessary information about the injury/illness with appropriate school personnel.

Name of Parent or Guardian, or student if 18 years of age (PRINTED) \_\_\_\_\_ Signature of Parent or Guardian, or student if age 18 years of age \_\_\_\_\_  
 Address (Street/PO Box, City, State, Zip) \_\_\_\_\_ Phone Number \_\_\_\_\_

*This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. 08/15*