

ATHLETIC PHYSICAL FORM

Students entering the 7th, 9th and 11th grades must have a complete physical at their doctors' office.

PRE-PARTICIPATION MEDICAL HISTORY

Student Name _____ Male ___ Female ___ Date of Birth _____ Grade in Fall _____
Address _____ School _____
Parents Name _____ Family Physician/Pediatrician _____

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 below.**)

Circle the appropriate answer:

- YES NO 1. Have you passed out or nearly passed out during exercise?
- YES NO 2. Have you experienced chest pain or pressure in your chest with exercise?
- YES NO 3. Does your heart race or skip beats during exercise?
- YES NO 4. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, or a heart infection? (Please explain below what the results of those tests were and any recommendations you were given by a doctor.)
- YES NO 5. Does anyone in the family have Marfan's Syndrome?
- YES NO 6. Is there anyone in your immediate family who died of heart problems or sudden death before age 50?
- YES NO 7. Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)? (Explain below any results).
- YES NO 8. Have you ever experienced heat exhaustion, heat stroke or heat related problems?

Use this space to explain any of the above numbered YES answers or to provide additional information:

PARENT OR GUARDIAN PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information in this form and will **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/ daughter at an athletic event in case of injury.

Typed or Printed Name of Parent/Guardian

Signature of Parent/Guardian

Student Signature

SCREENING EXAM FOR ATHLETIC PARTICIPATION

Blood Pressure: _____

Cardiac Exam:

Normal _____

Abnormal _____

Exception or Limitations for participation: _____

Date _____

Signature of Licensed Medical Professional _____

**Marshalltown Community Schools
Marshalltown, Iowa 50158**

As a parent of _____, who desires to participate in the athletic program of the Marshalltown Community School District, I understand that he/she cannot engage in athletic competition unless he/she is covered by:

A- Student Assurance Services, INC. (insurance available to students)

B- A family insurance program

C- Signed form waiving the insurance requirement

Please sign “one” of the following statements:

A. I have or will purchase the insurance provided through the school for my son/daughter for the _____ school year.

Date: _____ Signature: _____
Parent/Guardian

B. I have adequate insurance for my son/daughter.

Date: _____ Signature: _____
Parent/Guardian

C. Please waive the insurance requirement for athletic participation and allow my son/daughter to participate in athletics for the _____ school year.

Date: _____ Signature: _____
Parent/Guardian