SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for_____ GRADE _____
Name (Please Print) 2012-2013 School Year

who was born at _____
City, Town, County, State

on _____ to compete in SDHSAA approved athletics for _____ High School during the 2012-2013 school year.
Date of Birth

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury, which is inherent in all sports.

Date _____Signed_____
Parent or Legal Guardian

INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(NOTE: ***This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.***)

DATE OF EXAM _____ **NAME**_____ **GRADE** _____**DATE OF BIRTH** _____

SEX _____ **AGE** _____ **SCHOOL** _____ **SPORT(S)** _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking _____

_____

Do you have any allergies? ❑Yes ❑No If yes, please identify specific allergy. ❑ Medicines ❑ Pollens ❑ Food ❑ Stinging Insects

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

GENERAL QUESTIONS		YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have an ongoing medical condition? ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections Other _____		
3.	Have you ever spent the night in the hospital?		
4.	Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		**YES**	**NO**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
7.	Does your heart race or skip beats (irregular beats) during exercise?		
8.	Has a doctor ever you that you have any heart problems? ❑ High blood pressure ❑ heart murmur ❑ high cholesterol ❑ heart infection ❑ Kawasaki disease Other _____		
9.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?		
11.	Have you ever had an unexplained seizure?		
12.	Do you get more tired or short of break more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		**YES**	**NO**
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14.	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?		
15.	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS		**YES**	**NO**
17.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18.	Have you had any broken or fractured bones or dislocated joints?		
19.	Have you had a bone or joint injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast or crutches?		
20.	Have you ever had a stress fracture?		
21.	Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability (down syndrome or dwarfism)?		
22.	Do you regularly use a brace, orthotics, or other assistive device?		
23.	Do you have a bone, muscle, or joint injury that bothers you?		
24.	Do any of your joints become painful, swollen, feel warm or look red?		
25.	Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS		YES	NO
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27.	Have you ever used an inhaler or taken asthma medicine?		
28.	Is there anyone in your family who has asthma?		
29.	Where you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30.	Do you have groin pain or a painful bulge or hernia in the groin area?		
31.	Have you had infectious mononucleosis (mono) within the last month?		
32.	Do you have any rashes, pressure sores, or other skin problems?		
33.	Have you had a herpes or MRSA skin infection?		
34.	Have you ever had a head injury or concussion?		
35.	Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36.	Do you have a history of seizure disorder?		
37.	Do you have headaches with exercise?		
38.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39.	Have you ever been unable to move your arms or legs after being hit or falling?		
40.	Have you ever become ill when exercising in the heat?		
41.	Do you get frequent muscle cramps when exercising?		
42.	Do you or someone in your family have sickle cell trait or disease?		
43.	Have you had any problems with your eyes or vision?		
44.	Have you had any eye injuries?		
45.	Do you wear glasses or contact lenses?		
46.	Do you wear protective eyewear, such as goggles or a face shield?		
47.	Do you worry about your weight?		
48.	Are you trying to or has anyone recommended that you gain or lose weight?		
49.	Are you on a special diet or do you avoid certain types of foods?		
50.	Have you ever had an eating disorder?		
51.	Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY:			
52.	Have you ever had a menstrual period?		
53.	How old were you when you had your first menstrual period?		
54.	How many periods have you had in the last 12 months?		

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**_____

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION PHYSICAL EXAMINATION FORM

Date Exam Expires:_____

Check Appropriate Physical Exam Term:

_____**Annual** _____**Biennial**_____**Triennial**

NAME _____GRADE _____DATE OF BIRTH_____

CHECK ONE: _____ MALE _____FEMALE (2012-2013 School Year)

1. Blood pressure (sitting) _____/_____ Repeat in 5 minutes, if elevated _____/_____.
2. Height _____
3. Weight _____

	Normal	**Abnormal**	**COMMENTS**
4. Vision 20/____(L) 20/_____(R)	_____	_____	_____
5. Head	_____	_____	_____
6. Mouth (dentures, braces?)	_____	_____	_____
7. Eyes (contacts?)	_____	_____	_____
8. Chest/lung	_____	_____	_____
9. Heart			
a. Heart sounds	_____	_____	_____
b. Murmurs	_____	_____	_____
c. pulse discrepancy (rad. vs fem.)	_____	_____	_____
d. abnormal rhythm	_____	_____	_____
10. Abdomen			
a. liver or spleen enlargement	_____	_____	_____
b. masses	_____	_____	_____
11. Genitalia			
a. hernias	_____	_____	_____
b. testes	_____	_____	_____
12. Orthopedic			
a. cervical spine	_____	_____	_____
b. shoulder shrug	_____	_____	_____
c. deltoid	_____	_____	_____
d. arms/elbow	_____	_____	_____
e. hands	_____	_____	_____
f. hips	_____	_____	_____
g. knees	_____	_____	_____
h. ankles	_____	_____	_____
i. Scoliosis	_____	_____	_____

SPORTS PARTICIPATION RECOMMENDED FOR:

_____Cleared for ALL (*collision, contact/endurance sports, and other sports*)

_____Cleared only for *contact/endurance sports,* and *other sports*

_____Cleared only for *other sports*

D**efinition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]**

_____Cleared for ALL, but with recommendations for further evaluation or treatment for _____

_____Above clearance to be granted only after _____

_____**Clearance cannot be given at this time because** _____

NAME OF EXAMINER (PRINT) _____DATE _____, 20 _____

SIGNATURE OF EXAMINER _____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physicians Assistant and licensed Nurse Practitioner.