MIAA RECOMMENDED SPORTS CANDIDATE MEDICAL QUESTIONNAIRE

(Reference MIAA Rule 56)

PART A *- HISTORY*

DATE of EXAM:

Student's Name: **Gender:** **Age:** **Date of Birth:**

Grade: **School:**

Sport(s): Fall: Winter: Spring:

Address: **Tel.:**

Physician: **Tel.:**

IN CASE OF AN EMERGENCY, CONTACT:

Name: **Relationship:**

Tel (H): **Tel (W):**

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DO NOT KNOW THE ANSWER TO.

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical?	○	○
2.	Have you ever been hospitalized overnight?	○	○
3.	Have you ever had surgery?	○	○
4.	Do you have a missing or diseased paired organ?	○	○
5.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	○	○
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	○	○
7.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	○	○
8.	Have you ever had a rash or hives develop during or after exercise?	○	○
9.	Have you ever passed out during or after exercise?	○	○
10.	Have you ever been dizzy during or after exercise?	○	○
11.	Have you ever had chest pain during or after exercise?	○	○
12.	Do you get tired more quickly than your friends do during exercise?	○	○
13.	Have you ever had racing of your heart or skipped heartbeat?	○	○
14.	Have you had high blood pressure or high cholesterol?	○	○
15.	Have you ever been told you have a heart murmur?	○	○
16.	Has any family member or relative died of heart problems or of sudden death before age 50?	○	○
17.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	○	○
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?	○	○
19.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	○	○
20.	Have you ever had a head injury or concussion?	○	○
21.	Have you ever been knocked out, become unconscious, or lost your memory?	○	○
22.	Have you ever had a seizure?	○	○
23.	Do you have frequent or severe headaches?	○	○
24.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	○	○
25.	Have you ever had a stinger, burner, or pinched nerve?	○	○
26.	Have you ever become ill from exercising in the heat?	○	○
27.	Do you cough, wheeze, or have trouble breathing during or after activity?	○	○
28.	Do you have asthma?	○	○
29.	Do you have seasonal allergies that require medical treatment?	○	○

		YES	NO
30.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	○	○
31.	Have you had any problems with your eyes or vision?	○	○
32.	Do you wear glasses, contacts, or protective eyewear?	○	○
33.	Have you ever had a sprain, strain, or swelling after injury?	○	○
34.	Have you broken or fractured any bones or dislocated any joints?	○	○
35.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below: Head, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Hip, Thigh, Knee, Shin/Calf, Ankle, Foot		
36.	Do you want to weigh more or less than you do now?	○	○
37.	Do you lose weight regularly to meet weight requirements for your sport?	○	○
38.	Do you feel stressed out?	○	○
39.	Record the dates of your most recent immunizations (shots) for: Tetanus: Measles: Hepatitis B: Chickenpox:		

Explain "Yes" answers here:

FEMALES ONLY

40. When was your first menstrual period?
41. When was your most recent menstrual period?
42. How much time do you usually have from the start of one period to the start of another?
43. How many periods have you had in the last year?
44. What was the longest time between periods in the last year?

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Signature of athlete: Date:

Signature of Parent/Guardian: Date:

Revised: 6/19/2020

PART – B PHYSICAL EXAMINATION **DATE of EXAM:**

STUDENT: **Date of birth:**

Height: **Weight:** **% Body Fat (optional):**

Pulse: **BP:** / (/ , /)

Eyes: R20 / L20 /

Corrected: ☐ Yes ☐ No **Pupils:** Equal Unequal

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance	☐		
Eyes/Ears/Nose/Throat	☐		
Lymph Nodes	☐		
Heart	☐		
Pulses	☐		
Lungs	☐		
Abdomen	☐		
Genitalia (males only)	☐		
Skin	☐		
MUSCULOSKELETAL			
Neck	☐		
Back	☐		
Shoulder/Arm	☐		
Elbow/Forearm	☐		
Wrist/Hand	☐		
Hip/Thigh	☐		
Knee	☐		
Leg/Ankle	☐		
Foot	☐		

Station-based examination only

PART C – CLEARANCE

○ Cleared

○ Cleared after completing evaluation/rehabilitation for:

○ Not cleared for:

Reason:

Name of physician:

Signature of physician:

Address: **Tel.:**

Revised: 6/19/2020