

PHYSICAL EXAMINATION INSTRUCTIONS

I. Requirement of School Boards.

- A. Each governing board shall decide if the exam is to be repeated on an annual basis, on a biennial basis or triennial basis.
- B. Each governing board shall decide whether they want the doctors to evaluate sexual maturity based upon the Tanner Maturation Index. Please white-out item 13 on the Physical Exam form if the decision is NOT to use the Tanner Maturation Index.

II. Requirements of Member Schools.

- A. Each member school shall make copies of the forms that must be completed by the parents and/or doctors in sufficient quantities to meet your needs.
- B. Member schools must keep on file the following:

1. A copy of the **PARENT PERMIT FORM**. This form must be submitted annually.
2. A copy of the **INITIAL PRE-PARTICIPATION HISTORY** report for each student who takes the comprehensive exam for the first time. This form must be made available to the medical examiner at the time the student takes his/her first physical exam.
3. A copy of the **INTERIM PRE-PARTICIPATION HISTORY** for each student must be submitted annually by the parents except on the very first occasion when the **INITIAL PRE-PARTICIPATION HISTORY** is required.

All questions on the **INTERIM PRE-PARTICIPATION HISTORY** form should be answered with the following in mind: **IN THE PAST YEAR:** Please explain any yes answers in the space provided on the form. Any yes answers may require a re-visit to the medical provider for re-certification of health. The parent/guardian signature denotes that the student is physically able to participate.

4. A copy of the comprehensive **PHYSICAL EXAMINATION** signed by either a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner.
- C. Member schools may commence scheduling physical exams as early as April 1 for the ensuing school year.

III. Role of Doctors, Physician Assistant and Nurse Practitioners.

- A. The certification/signing of the physical exam form is reserved for only a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, a Physician Assistant or Nurse Practitioner. Stamping the name of a medical clinic or a medical association as a substitute for the authorized signature is unacceptable. All exams must be signed by authorized medical personnel as listed in paragraph two above.
- B. The examiner shall receive a copy of Instructions for conducting the orthopedic screening and other portions of the exam. The instruction sheet follows the other forms located in this section of this publication.
- C. The medical history form must be made available to the person(s) conducting the physical exam at the time the examination takes place.

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION

PHYSICAL EXAMINATION ITEMS TO BE EVALUATED

Station 1 - Individual History

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

Station 2 - Blood Pressure

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75
12 years and older 140/85

Station 3 - Vision (Snellen)

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

Station 4 - Skin, Mouth, Eyes, Ears

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

Station 5 - Chest

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

Station 6 - Lymphatics, Abdomen, Genitalia

Cervical or axillary adenopathy, organomegaly, absence of testicles, hernia, and Tanner maturation index.

Station 7 - Orthopedic

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

Station 8 - Review

Check all categories that apply.

- All Sports (collision, contact/endurance, other)
- Contact/Endurance Sports only due to
- Other Sports Only due to
- Sports Participation Not Recommended, due to
- Approval Withheld Pending evaluation for

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

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ORTHOPEDIC SCREENING GUIDE**

Athletic Activity (Instructions)	Observation
Stand Facing Examiner	General habitus; acromioclavicular joints
Look at ceiling, floor, over both shoulders; touch ears to shoulders	Cervical spine motion
Shrug shoulders (examiner resists)	Trapezius strength
Abduct shoulder 90 degrees (examiner resists at 90 degrees)	Deltoid strength
Full external rotation of arms	Shoulder motion
Flex and extend elbows	Elbow motion
Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists	Elbow and wrist motion
Spread fingers; make fist	Hand or finger motion and deformities
Tighten (contact) quadriceps; relax quadriceps	Symmetry and knee effusion; ankle effusion
"Duck walk" four steps (away from the examiner with buttocks on heels)	Hip, knee and ankle motion
Back to examiner; knees straight, touch toes	Shoulder symmetry; scoliosis, hip motion, hamstring tightness
Raise up on toes, raise heels	Calf symmetry, leg strength

May require reflex hammer, tape measure, pin, and examination table.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2011-12 School Year

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

on _____ to compete in SDHSAA approved athletics for _____ High School
Date of Birth

during the 2011-2012 school year.

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 _____, 20____ Signed _____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INITIAL PRE-PARTICIPATION HISTORY

**SEE REVERSE SIDE FOR
HEALTH HISTORY QUESTIONNAIRE**

INITIAL PRE-PARTICIPATION HISTORY

(This form must be completed prior to the taking of a physical examination.)

NAME _____ GRADE _____ DATE OF BIRTH _____
 (2011-12 School Year)

		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 (like diabetes or asthma)?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does your heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan Syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or 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, surgery, injections, rehabilitation, physical therapy, a brace, a 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 atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.	Is there anyone in your family who has asthma?		
26.	Have you ever used an inhaler or taken asthma medicine?		
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28.	Have you had infectious mononucleosis (mono) within the last month?		

		YES	NO
29.	Do you have any rashes, pressure sores, or other skin problems?		
30.	Have you had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you happy with your weight?		
43.	Are you trying to gain or lose weight?		
44.	Has anyone recommended you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		
47.	Are there other sports that you would like to participate in that were not approved at a previous examination?		

FEMALES ONLY:

48.	Have you ever had a menstrual period?		
49.	How old were you when you had your first menstrual period?		
50.	How many periods have you had in the last 12 months?		

Explain "Yes" answers here: _____

(continue on front side of this form if necessary)

I do not know of any additional health reason which should keep this student from participating in interscholastic athletics. I certify that the answers to the above questions are true.

SIGNED _____ DATE _____, 20____
 Signature of Parent or Guardian



**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 (2011-12 School Year)

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

2. Height _____

3. Weight _____

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 (rad. vs fem.)

d. rhythm

10. Abdomen

a. liver or spleen

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

13. Tanner Maturation Index (Optional) Circle: I II III IV V

SPORTS PARTICIPATION RECOMMENDED FOR:

_____ All Sports: collision, contact/endurance, other

_____ Contact/Endurance Sports only due to

_____ Other Sports Only due to

_____ Sports Participation Not Recommended, due to

_____ Approval Withheld Pending evaluation for

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

NAME OF EXAMINER _____ DATE _____, 20__

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 Physician Assistant and licensed Nurse Practitioner.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2011-12 SCHOOL YEAR

who was born at _____ on _____
City, Town, County, State Date of Birth

to compete in SDHSAA approved athletics for _____ High School during the 2011-2012 school year.

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.

Signed _____ Date _____, 20____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

**SEE REVERSE SIDE FOR
HEALTH HISTORY QUESTIONNAIRE**

INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

NAME _____ GRADE _____ DATE OF BIRTH _____
 (2011-12 School Year)

IN THE PAST YEAR:

		YES	NO			YES	NO
1.	Has a doctor denied your participation in sports for any reason?			17.	Have you had a stress fracture?		
2.	Do you have a new ongoing medical condition (like diabetes or asthma)?			18.	Did a doctor tell you that you have asthma or allergies?		
3.	Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?			19.	Have you started to cough, wheeze, or have difficulty breathing during or after exercise?		
4.	Do you have new allergies to medicines, pollens, foods, or stinging insects?			20.	Have you used an inhaler or taken asthma medicine?		
5.	Have you passed out or nearly passed out DURING exercise?			21.	Have you lost a kidney, an eye, a testicle, or any other organ?		
6.	Have you passed out or nearly passed out AFTER exercise?			22.	Do you have any new rashes, pressure sores, or other skin problems?		
7.	Have you had discomfort, pain, or pressure in your chest during exercise?			23.	Have you had a new herpes skin infection?		
8.	Has your heart raced or skipped beats during exercise?			24.	Have you had a head injury or concussion?		
9.	Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?			25.	Have you been hit in the head and been confused or lost your memory?		
10.	Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)			26.	Have you had a seizure?		
11.	Has anyone in your family died for no apparent reason?			27.	Have you experienced headaches with exercise?		
12.	Have you spent the night in a hospital?			28.	Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
13.	Have you had surgery?			29.	Have you been unable to move your arms or legs after being hit or falling?		
14.	Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?			30.	When exercising in the heat, did you have severe muscle cramps or become ill?		
15.	Have you had any broken or fractured bones or dislocated joints?			Explain "Yes" answers here: _____ _____ _____ _____ _____			
16.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?			(continue on front side of this form if necessary)			

RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

_____, 20_____
 Date Signature of Parent

This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

CONSENT FOR MEDICAL TREATMENT

I am the _____ (Mother-Father-Legal Guardian)
of _____, who participates in co-curricular activities
for _____ High School. I hereby consent to any
medical services that may be required while said child is under the supervision of an employee of
_____ School District while on a school-sponsored
activity and hereby appoint said employee to act on behalf in securing necessary medical services from
any duly licensed medical provider.

Dated this _____ day of _____, 20_____

Parent's Signature: _____

CONSENT OF CHILD

I, _____, have read the above Consent form signed by
my _____ (Mother-Father-Legal Guardian) and join
with _____ (him/her) in the consent.

Dated this _____ day of _____, 20_____

Student's Signature: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 20_____.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

Signature of Parent

Date

This form must be completed annually and must be available for inspection at the school