

**BISHOP KELLY HIGH SCHOOL / IHSAA  
HEALTH EXAMINATION AND CONSENT FORM**

Each year, all athletes are required to complete a History and Physical examination prior to his/her first practice in the interscholastic (9-12) athletic program. The exam is at the expense of the student and may not be taken prior to May 1 of the preceding school year. This exam is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. **PLEASE PRINT ALL INFORMATION ON THIS FORM!**

Name \_\_\_\_\_ Home Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
 IHSAA Sanctioned Sports:    Football    Volleyball    Soccer    Cross Country    Basketball    Wrestling  
     Baseball    Softball    Track    Tennis    Golf

**HISTORY FORM (Completed by athlete and/or parent/guardian)**

\*Fill in details of "YES" answers in the space below:

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
1.A. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	(itching, rash, acne)		
2. Are you presently taking any medication or pills?	<input type="checkbox"/>	<input type="checkbox"/>	6.A. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	B. Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
(medicine, bees, other stinging insects)			C. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
4.A. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	D. Have you ever had a stinger, burner, or		
B. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
C. Have you ever had chest pain during/after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	7.A. Have you ever had heats cramps?	<input type="checkbox"/>	<input type="checkbox"/>
D. Do you tire more quickly than your friends during			B. Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
exercise?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have trouble breathing or coughing during/after	<input type="checkbox"/>	<input type="checkbox"/>
E. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	exercise?	<input type="checkbox"/>	<input type="checkbox"/>
F. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you use special equipment, pads, braces, mouth or		
G. Have you ever had racing of your heart or			eyeguards?	<input type="checkbox"/>	<input type="checkbox"/>
or skipped beats?	<input type="checkbox"/>	<input type="checkbox"/>	10.A. Have you had problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
H. Has anyone in your family died of heart problems			B. Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
a sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever sprained/strained, dislocated, fractured/broken, or had repeated swelling or other injuries of any of your bones or joints?					
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Back <input type="checkbox"/> Hip					
<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand					
<input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot					

12. Have you ever had any other medical problems such as:

<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Headaches (frequent)
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Eye injuries	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Other	

13. Have you had a medical problem or injury since your last exam? \_\_\_\_\_

14. When was your last tetanus shot? \_\_\_\_\_

15. When was your last measles immunization? \_\_\_\_\_

16. When was your first menstrual period? \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_

What was the longest time between periods last year? \_\_\_\_\_

\*Explain "YES" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CONSENT FORM**

(Parent/Guardian and Student Permission and Approval)

I hereby consent to the above named student participating in the interscholastic athletic program at Bishop Kelly High School. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

This application to compete in interscholastic athletics for Bishop Kelly High School is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Idaho High School Activities Association.

**SIGNATURE OF ATHLETE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PHYSICAL EXAMINATION FORM**  
**(Completed by licensed physician, physician's assistant, or nurse practitioner.)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ PB \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_  
 Visual acuity R 20 / \_\_\_\_\_ L 20 / \_\_\_\_\_ Corrected Yes No Pupils \_\_\_\_\_

	Normal	Abnormal
Ears, Nose, Throat	_____	_____
Cardiopulmonary		
Pulses	_____	_____
Heart	_____	_____
Lungs	_____	_____
Skin	_____	_____
Abdominal	_____	_____
Genitalia	_____	_____
Musculoskeletal		
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____

**CLEARANCE / RECOMMENDATIONS**

Clearance:

- Cleared** for all sports and other school-sponsored activities.
  
- Cleared after completing** evaluation / rehabilitation for: \_\_\_\_\_
  
- NOT cleared** to participate in the following IHSAA sponsored sports:
 

<input type="checkbox"/> Football	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Soccer	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Basketball	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Baseball	<input type="checkbox"/> Softball	<input type="checkbox"/> Track	<input type="checkbox"/> Tennis	<input type="checkbox"/> Golf	
- NOT cleared** for other school-associated activities:
 

<input type="checkbox"/> Swimming	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
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- Student is **NOT permitted to participate** in high school athletics. Reason: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (This physical form must be signed by a licensed physician, physician's assistant, or nurse practitioner.)

Address \_\_\_\_\_ Phone (        ) \_\_\_\_\_

**RETURN COMPLETED FORM TO:**

Athletic Trainer  
 Bishop Kelly High School  
 7009 Franklin Road  
 Boise, ID 83709