



TREASURE VALLEY

CLASSICAL ACADEMY

HEALTH EXAMINATION AND CONSENT FORM

Every student must complete a medical history questionnaire and a physical examination prior to his/her first practice in a middle-school (grades 6-8) athletic program in the State of Idaho. The examination is at the expense of the student and may not be taken prior to May 1 for the following year's activities. This examination is to be performed by a licensed physician, physician's assistant, or nurse practitioner under optimal conditions. Students who complete this examination will be required to submit interim medical history forms during subsequent middle-school years.

Student Name

Date of Birth

Address

Age

Phone

Grade

Sports

Sex (circle): M / F

Medical History

Check if 'Yes':

- ☐ Have you ever been hospitalized?
- ☐ Have you ever had surgery?
- ☐ Are you presently taking any medication or pills?
- ☐ Do you have any allergies (medicine, bees, other insects)?
- ☐ Have you ever passed out during or after exercise?
- ☐ Have you ever been dizzy during or after exercise?
- ☐ Have you ever had chest pain during or after exercise?
- ☐ Do you tire more quickly than your friends during exercise?
- ☐ Have you ever had high blood pressure?
- ☐ Have you been told you have a heart murmur?
- ☐ Have you ever had racing of your heart or skipped heartbeats?
- ☐ Has anyone in your family died of heart problems or a sudden death before age 50?
- ☐ Do you have any skin problems (itching, rash, acne)?
- ☐ Have you ever had a head injury?
- ☐ Have you ever been knocked out or unconscious?
- ☐ Have you ever been diagnosed with a concussion?
- ☐ Have you ever had a seizure?
- ☐ Have you ever had a stinger, burned, or pinched nerve?
- ☐ Have you ever had heat or muscle cramps?
- ☐ Have you ever been dizzy or passed out in the heat?
- ☐ Do you have trouble breathing or do you cough during or after exercise?
- ☐ Do you use special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
- ☐ Have you ever had problems with your eyes or vision?
- ☐ Do you wear glasses, contacts, or protective eyewear?
- ☐ Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?
- ☐ Have you had a medical problem or injury since your last evaluation?
- ☐ Were you born without a kidney, testicle, or any other organ?

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HEALTH AND PHYSICAL EXAMINATION FORM

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Check if you have ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of the following bones or joints:

- | | | | |
|--------------------------------|-----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | <input type="checkbox"/> Shin |
| <input type="checkbox"/> Back | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh | <input type="checkbox"/> Foot |

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

Explain any 'Yes' answers:

Consent

(Parent or guardian and student permission and approval)

I hereby consent to the above-named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated school authorities for any illness or injury resulting from his/her athletic participation. I also consent to release of any information contained in this form to carry out treatment and healthcare operations for the above-named student. If the health care provider's exam will be performed without compensation as part of the school's health examination program for participation in high school activities, I agree to the waiver provisions as set forth in Idaho Code Section 39-7703 and agree that the health care provider shall be immune from liability as specified in said section.

Parent or Guardian Signature

Date (mm/dd/yy)

Student Signature

Date (mm/dd/yy)

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PHYSICAL EXAMINATION FORM

Name: _____

Date of Birth: _____

Height: _____ Weight: _____ / _____ BP: _____ Pulse: _____		
Vision: R 20 / _____ Vision: L 20 / _____ Corrected: Y / N		
	Normal	Abnormal Findings
Medical		
Pulses		
Heart		
Lungs		
Skin		
Ears, Nose, Throat		
Abdomen		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE/RECOMMENDATIONS

The examiner should circle and comment on all that apply.

A. Cleared for all sports and other school-sponsored activities.

B. Cleared after completing evaluation/rehabilitation for:

C. NOT cleared to participate in the following IHSAA sponsored sports/activities (circle):

Cross Country Volleyball Wrestling Basketball Soccer

D. NOT cleared for other school-sponsored activities (example: lacrosse):

E. Student is NOT permitted to participate in high school athletics.

Reason:

F. Recommendation:

Name of Physician:

Date:

Phone:

Signature of Physician:

Address:
