



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?	<input type="radio"/>	<input type="radio"/>
2.	Have you ever been hospitalized overnight?	<input type="radio"/>	<input type="radio"/>
3.	Have you ever had surgery?	<input type="radio"/>	<input type="radio"/>
4.	Do you have a missing or diseased paired organ?	<input type="radio"/>	<input type="radio"/>
5.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="radio"/>	<input type="radio"/>
6.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="radio"/>	<input type="radio"/>
7.	Have you ever had a rash or hives develop during or after exercise?	<input type="radio"/>	<input type="radio"/>
8.	Have you ever passed out during or after exercise?	<input type="radio"/>	<input type="radio"/>
9.	Have you ever been dizzy during or after exercise?	<input type="radio"/>	<input type="radio"/>
10.	Have you ever had chest pain during or after exercise?	<input type="radio"/>	<input type="radio"/>
11.	Do you get tired more quickly than your friends do during exercise?	<input type="radio"/>	<input type="radio"/>
12.	Have you ever had racing of your heart or skipped heartbeat?	<input type="radio"/>	<input type="radio"/>
13.	Have you had high blood pressure or high cholesterol?	<input type="radio"/>	<input type="radio"/>
14.	Have you ever been told you have a heart murmur?	<input type="radio"/>	<input type="radio"/>
15.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="radio"/>	<input type="radio"/>
16.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="radio"/>	<input type="radio"/>
17.	Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="radio"/>	<input type="radio"/>
18.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="radio"/>	<input type="radio"/>
19.	Have you ever had a head injury or concussion?	<input type="radio"/>	<input type="radio"/>
20.	Have you ever been knocked out, become unconscious, or lost your memory?	<input type="radio"/>	<input type="radio"/>
21.	Have you ever had a seizure?	<input type="radio"/>	<input type="radio"/>
22.	Do you have frequent or severe headaches?	<input type="radio"/>	<input type="radio"/>
23.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="radio"/>	<input type="radio"/>
24.	Have you ever had a stinger, burner, or pinched nerve?	<input type="radio"/>	<input type="radio"/>
25.	Have you ever become ill from exercising in the heat?	<input type="radio"/>	<input type="radio"/>
26.	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="radio"/>	<input type="radio"/>
27.	Do you have asthma?	<input type="radio"/>	<input type="radio"/>
28.	Do you have seasonal allergies that require medical treatment?	<input type="radio"/>	<input type="radio"/>

		YES	NO
29.	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)?	<input type="radio"/>	<input type="radio"/>
30.	Have you had any problems with your eyes or vision?	<input type="radio"/>	<input type="radio"/>
31.	Do you wear glasses, contacts, or protective eyewear?	<input type="radio"/>	<input type="radio"/>
32.	Have you broken or fractured any bones or dislocated any joints?	<input type="radio"/>	<input type="radio"/>
33.	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	Elbow	Hip
	Neck	Forearm	Thigh
	Back	Wrist	Knee
	Chest	Hand	Shin/Calf
	Shoulder	Finger	Ankle
	Upper Arm		Foot

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:



PART – B PHYSICAL EXAMINATION

DATE of EXAM:

STUDENT:

Date of birth:

Height:

Weight:

Pulse:

BP:

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

**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.: