



# MONTANA HIGH SCHOOL ASSOCIATION

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PROMOTING SUCCESS ON THE COURT, ON THE FIELD, ON STAGE  
AND EVERYWHERE ELSE UNDER THE BIG SKY SINCE 1921.

May 2023

**TO: PARENTS OF MHSA SPORTS PARTICIPANTS  
LICENSED MEDICAL PROFESSIONALS**

**FROM: BRIAN MICHELOTTI, EXECUTIVE DIRECTOR**

**RE: UPDATED MHSA PRE-PARTICIPATION PHYSICAL EXAM FORM**

Article II, Section (3) of the MHSA Handbook requires that a physical exam must be performed for each student for that student to be considered eligible for participation in an Association Contest. Physical exams must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. A physical examination conducted before May 1<sup>st</sup> is not valid for participation for the following school year.

Logan Health, the official health care provider of the MHSA, is a new sponsor of the MHSA Pre-Participation Physical Form. Parents/guardians may use the medial provider of their choice for the Pre-Participation Physical Examination for their student athlete.

The MHSA Executive Board approved important additions to this form. Specifically, questions concerning the cardiac history and cardiac health of the student were added (questions 6-15), and an updated section on vaccinations which needs to be complete. **This year, the two questions regarding COVID-19 have been removed.**

This MHSA pre-participation form is the only form that will be allowed for the student's exam (**no other forms will be accepted**). The following process should be followed:

- Parent(s)/legal guardian(s) and their student will fill out the questionnaire and history portion of the form together.
- A medical provider will review the form with the student and parent/guardian and perform the exam. A signature from the medical provider is required to clear the student for participation.
- The student and parent/guardian will sign the form.
- The completed MHSA pre-participation form physical exam will be given to the appropriate school administrator.

The MHSA is committed to the safety and health of our student activity participants and believes this new form will facilitate that objective.

If you have any questions regarding the updated pre-participation examination form, please contact me.



MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. While Logan Health is the preferred medical provider of the MHSA, parents/guardians may choose their own medial provider for their Physical Examination This certification is valid for a period of one school year. A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)
Name \_\_\_\_\_ Male [ ] Female [ ] Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_
Home Address \_\_\_\_\_ Phone Number \_\_\_\_\_
Parent's Name \_\_\_\_\_ Family Physician \_\_\_\_\_
Current School \_\_\_\_\_ Date \_\_\_\_\_

Explain "Yes" answers below. Circle questions to which you don't know the answer.

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 nonprescription (over-the-counter) medicines or pills? [ ] [ ]
4. Are you taking medicine for ADHD? [ ] [ ]
5. Do you have allergies to medicines, pollens, foods, or stinging insects? [ ] [ ]
6. Have you ever passed out or nearly passed out DURING exercise? [ ] [ ]
7. Have you ever passed out or nearly passed out AFTER exercise? [ ] [ ]
8. Have you ever had discomfort, pain, or pressure in your chest during exercise? [ ] [ ]
9. Does your heart race or skip beats during exercise? [ ] [ ]
10. Has a doctor ever told you that you have (circle all that apply):
High blood pressure A heart murmur
High cholesterol A heart infection
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) [ ] [ ]
12. Has anyone in your family died for no apparent reason? [ ] [ ]
13. Does anyone in your family have a heart problem? [ ] [ ]
14. Has any family member or relative died of heart problems or of sudden death before age 50? [ ] [ ]
15. Does anyone in your family have Marfan syndrome? [ ] [ ]
16. Have you ever spent the night in a hospital? [ ] [ ]
17. Have you ever had surgery? [ ] [ ]
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below: [ ] [ ]
19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: [ ] [ ]
20. 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? If yes, circle below: [ ] [ ]
21. Have you ever had a stress fracture? [ ] [ ]
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? [ ] [ ]
23. Do you regularly use a brace or assistive device? [ ] [ ]
24. Has a doctor ever told you that you have asthma or allergies? [ ] [ ]
25. Do you cough, wheeze, or have difficulty breathing during or after exercise? [ ] [ ]
26. Is there anyone in your family who has asthma? [ ] [ ]
27. Have you ever used an inhaler or taken asthma medicine? [ ] [ ]
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? [ ] [ ]
29. Have you had infectious mononucleosis (mono) within the last month? [ ] [ ]
30. Do you have any rashes, pressure sores, or other skin problems? [ ] [ ]
31. Have you had a herpes skin infection? [ ] [ ]
32. Have you ever had a head injury or concussion? [ ] [ ]
33. Have you been hit in the head and been confused or lost your memory? [ ] [ ]
34. Have you ever had a seizure? [ ] [ ]
35. Do you have headaches with exercise? [ ] [ ]
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? [ ] [ ]
37. Have you ever been unable to move your arms or legs after being hit or falling? [ ] [ ]
38. When exercising in the heat, do you have severe muscle cramps or become ill? [ ] [ ]
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease? [ ] [ ]
40. Have you had any problems with your eyes or vision? [ ] [ ]
41. Do you wear glasses or contact lenses? [ ] [ ]
42. Do you wear protective eyewear, such as goggles or a face shield? [ ] [ ]
43. Are you happy with your weight? [ ] [ ]
44. Are you trying to gain or lose weight? [ ] [ ]
45. Have anyone recommended you change your weight or eating habits? [ ] [ ]
46. Do you limit or carefully control what you eat? [ ] [ ]
47. Do you have any concerns that you would like to discuss with a doctor? [ ] [ ]
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 year? \_\_\_\_\_
Explain "Yes" answers here: \_\_\_\_\_

Allergies: \_\_\_\_\_
Required for School\* and Recommended Immunizations: (please check if student is up-to-date): [ ] Hepatitis A; [ ] Hepatitis B; [ ] Human Papillomavirus (HPV); [ ] Influenza; [ ] Measles, Mumps, Rubella (MMR)\*; [ ] Meningococcal; [ ] Polio\*; [ ] Tetanus/Diphtheria/Pertussis (Tdap)\*; [ ] Varicella (Chickenpox)\*

Date of last known tetanus shot (Tdap): \_\_\_\_\_

**PROVIDER'S PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP: Left Arm \_\_\_\_\_ / \_\_\_\_\_ Right Arm \_\_\_\_\_ / \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

|                        | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|------------------------|--------|-------------------|-----------|
| <b>MEDICAL</b>         |        |                   |           |
| Appearance             |        |                   |           |
| Eyes/ears/nose/throat  |        |                   |           |
| Hearing                |        |                   |           |
| Lymph nodes            |        |                   |           |
| Heart                  |        |                   |           |
| Murmurs                |        |                   |           |
| Pulses                 |        |                   |           |
| Lungs                  |        |                   |           |
| Abdomen                |        |                   |           |
| Hernia                 |        |                   |           |
| Skin                   |        |                   |           |
| <b>MUSCULOSKELETAL</b> |        |                   |           |
| Neck                   |        |                   |           |
| Back                   |        |                   |           |
| Shoulder/arm           |        |                   |           |
| Elbow/forearm          |        |                   |           |
| Wrist/hands/fingers    |        |                   |           |
| Hip/thigh              |        |                   |           |
| Knee                   |        |                   |           |
| Leg/ankle              |        |                   |           |
| Foot/toes              |        |                   |           |

\*Multiple examiner set-up only.

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CLEARANCE**

Typed or printed name of Student \_\_\_\_\_ Signature of Student \_\_\_\_\_

Cleared without restriction  
 Cleared with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared for  All sports  Certain sports \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

Name of physician/medical provider [print or type] \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician/medical provider \_\_\_\_\_

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Insurance (Company name) \_\_\_\_\_

Parent's Home Phone \_\_\_\_\_

Parent's Work Phone \_\_\_\_\_

Parent's Cell Phone \_\_\_\_\_

Additional Phone (if any-specify) \_\_\_\_\_

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL**

(Updated (4/23))