**COPY THIS PAGE for the student to return to the school. KEEP the complete document in the student's medical record.**

# 2024-2025 SPORTS QUALIFYING PHYSICAL EXAMINATION MEDICAL ELIGIBILITY FORM

Minnesota State High School League

Student Name: _____ Birth Date: _____
Address: _____
Home Telephone: ____- ____- _____ Mobile Telephone _____
School: _____ Grade: _____

I certify that the above student has been medically evaluated and is deemed medically eligible to: (Check Only One Box)

☐ **(1) Participate in all school interscholastic activities without restrictions.**
☐ **(2) Participate in any activity not crossed out below.**

| *Sport Classification Based on Contact* | | |
|---|---|---|
| **Collision Contact Sports** | **Limited Contact Sports** | **Non-contact Sports** |
| Basketball<br>Cheerleading<br>Diving<br>Football<br>Gymnastics<br>Ice Hockey<br>Lacrosse<br>Alpine Skiing<br>Soccer<br>Wrestling | Baseball<br>Field Events:<br>❖ High Jump<br>❖ Pole Vault<br>Floor Hockey<br>Nordic Skiing<br>Softball<br>Volleyball | Badminton<br>Bowling<br>Cross Country Running<br>Dance Team<br>Field Events:<br>❖ Discus<br>❖ Shot Put<br>Golf<br>Swimming<br>Tennis<br>Track |

☐ **(3) Requires additional evaluation before a final recommendation can be made.**
Additional recommendations for the school or parents**:**

_____
_____

☐ **(4) Not medically eligible for:** ☐ **All Sports**
☐ **Specific Sports**

**Specify** _____

***Sport Classification Based on Intensity & Strenuousness***

| *Increasing Static Component* → | A. Low (<40% Max $O_2$) | B. Moderate (40-70% Max $O_2$) | C. High (>70% Max $O_2$) |
|---|---|---|---|
| III. High (>50% MVC) | Field Events:<br>❖ Discus<br>❖ Shot Put<br>Gymnastics*† | Alpine Skiing*†<br>Wrestling* | |
| II. Moderate (20-50% MVC) | Diving*† | Dance Team<br>Football*<br>Field Events:<br>❖ High Jump<br>❖ Pole Vault*†<br>Synchronized Swimming†<br>Track — Sprints | Basketball*<br>Ice Hockey*<br>Lacrosse*<br>Nordic Skiing — Freestyle<br>Track — Middle Distance<br>Swimming† |
| I. Low (<20% MVC) | Bowling<br>Golf | Baseball*<br>Cheerleading<br>Floor Hockey<br>Softball*<br>Volleyball | Badminton<br>Cross Country Running<br>Nordic Skiing — Classical<br>Soccer*<br>Tennis<br>Track — Long Distance |

*Increasing Dynamic Component* → → → → →

**Sport Classification Based on Intensity & Strenuousness:** This classification is based on peak static and dynamic components achieved during competition. It should be noted, however, that higher values may be reached during training. The increasing dynamic component is defined in terms of the estimated percent of maximal oxygen uptake ($MaxO_2$) achieved and results in an increasing cardiac output. The increasing static component is related to the estimated percent of maximal voluntary contraction (MVC) reached and results in an increasing blood pressure load. The lowest total cardiovascular demands (cardiac output and blood pressure) are shown in lightest shading and the highest in darkest shading. The graduated shading in between depicts low moderate, moderate, and high moderate total cardiovascular demands. *Danger of bodily collision. †Increased risk if syncope occurs. Reprinted with permission from: Maron BJ, Zipes DP. 36th Bethesda Conference: eligibility recommendations for competitive athletes with cardiovascular abnormalities. *J Am Coll Cardiol.* 2005; 45(8):1317–1375.

I have examined the student named on this form and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. The athlete does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Provider Signature _____ Date of Exam_____
Print Provider Name: _____
Office/Clinic Name _____ Address: _____
City, State, Zip Code _____
Office Telephone: ____- ____- _____ E-Mail Address: _____

**IMMUNIZATIONS** [Tdap; meningococcal (MCV4, 2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); hep A (2 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual); COVID-19 (2 doses, 1 dose)]
☐ Up to date (see attached school documentation) ☐ Not reviewed at this visit
**IMMUNIZATIONS GIVEN TODAY:** _____

**EMERGENCY INFORMATION**
**Allergies** _____
**Other Information** _____
Emergency Contact:_____ Relationship _____
Telephone: (Home) ____- ____- _____ (Work) ____- ____- _____ (Cell)_____
Personal Medical Provider _____ Office Telephone_____

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.
**FOR SCHOOL ADMINISTRATION USE:** ☐ [Year 2 Normal] ☐ [Year 3 Normal]

Reference: Preparticipation Physical Evaluation (5th Edition): AAFP, AAP, ACSM, AMSSM, AOSSM, AOASM; 2019.

# 2024-2025 SPORTS QUALIFYING PHYSICAL HISTORY FORM (Z02.5)

Minnesota State High School League

**Pages 2-5 of this document should be KEPT on file by the medical provider issuing the physical examination.**

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____
Date of examination: _____ Sport(s): _____
Sex assigned at birth - F, M, or intersex (circle) How do you identify your gender? (F, M, non-binary, or another gender)
Have you had a COVID-19/Influenza/RSV vaccinations? Y / N
Past and current medical conditions: _____
Have you ever had surgery? If yes, list all past surgeries. _____
List current medicines and supplements: prescriptions, over-the-counter, and herbal or nutritional supplements.
_____
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).
_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, evaluate.)

Circle Y for Yes, N for No, or the question number if you do not know the answer.

**GENERAL QUESTIONS**

1. Do you have any concerns that you would like to discuss with your provider? Y / N
2. Has a provider ever denied or restricted your participation in sports for any reason? Y / N
3. Do you have any ongoing medical issues or recent illness? Y / N

**HEART HEALTH QUESTIONS ABOUT YOU[a]**

4. Have you ever passed out or nearly passed out during or after exercise? Y / N
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Y / N
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Y / N
7. Has a doctor ever told you that you have any heart problems? Y / N
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y / N
9. Do you get light-headed or feel shorter of breath than your friends during exercise? Y / N
10. Have you ever had a seizure? Y / N

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY[a]**

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? Y / N
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? Y / N
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? Y / N

**BONE AND JOINT QUESTIONS**

14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? Y / N
15. Do you have a bone, muscle, ligament, or joint injury that bothers you? Y / N

**MEDICAL QUESTIONS**

16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y / N
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ? Y / N
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? Y / N
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Y / N
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Y / N
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? Y / N
22. Have you ever become ill while exercising in the heat? Y / N
23. Do you or does someone in your family have sickle cell trait or disease? Y / N
24. Have you ever had or do you have any problems with your eyes or vision? Y / N
25. Do you worry about your weight? Y / N
26. Are you trying to or has anyone recommended that you gain or lose weight? Y / N
27. Are you on a special diet or do you avoid certain types of foods or food groups? Y / N
28. Have you ever had an eating disorder? Y / N

**MENSTRUAL QUESTIONS**

29. Have you ever had a menstrual period? Y / N
30. How old were you when you had your first menstrual period? _____
31. When was your most recent menstrual period? _____
32. How many periods have you had in the past 12 months? _____

Notes: _____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____ Signature of parent or guardian: _____
Date: ___/___/_____

# 2024-2025 SPORTS QUALIFYING PHYSICAL EXAMINATION FORM (Z02.5)

Minnesota State High School League

**Pages 2-5 of this document should be KEPT on file by the medical provider issuing the physical examination.**

Student Name: _____ Birth Date: _____

**Follow-Up Questions About More Sensitive Issues:**

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you been hit, kicked, slapped, punched, sexually abused, inappropriately touched, or threatened with harm by anyone close to you?
5. Have you ever tried cigarette, cigar, pipe, e-cigarette smoking, or vaping, even 1 or 2 puffs? Do you currently smoke?
6. During the past 30 days, did you use chewing tobacco, snuff, or dip?
7. During the past 30 days, have you had any alcohol drinks, even just one?
8. Have you ever taken steroid pills or shots without a doctor's prescription?
9. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
10. Question “Risk Behaviors” like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.
11. Would you like to have a COVID-19 vaccination?

**Notes About Follow-Up Questions:**

_____

_____

## MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____
Pulse _____ BP in both arms R_____/_____(_____/_____) L____/____ (_____/_____)
Vision: R 20/_____L 20/_____Corrected: Y / N Contacts: Y / N Hearing: R_____ L_____(Audiogram or confrontation)

| Exam | Normal | Abnormal Findings | Initials** |
|---|---|---|---|
| **Appearance** | | | |
| Circle any Marfan stigmata present | → | Kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency | |
| **HEENT** | | | |
| Eyes | | | |
| Fundoscopic | | | |
| Pupils | | | |
| Hearing | | | |
| **Cardiovascular*** | | | |
| Describe any murmurs present (standing, supine, +/- Valsalva) | → | | |
| Pulses (simultaneous femoral & radial) | | | |
| **Lungs** | | | |
| **Abdomen** | | | |
| **Tanner Staging (optional)** | Circle | I II III IV V | |
| **Skin** (No HSV, MRSA, Tinea corporis) | | | |
| **Musculoskeletal** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand/Fingers | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot/Toes | | | |
| Functional (Double-leg squat test, single-leg squat test, and box drop, or step drop test) | | | |

*Consider ECG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or examination findings ** For Multiple Examiners

Additional Notes: _____

_____

Health Maintenance: ☐ Lifestyle, health, immunizations, & safety counseling ☐ Discussed dental care & mouthguard use
☐ Discussed Lead and TB exposure – (Testing indicated / not indicated) ☐ Eye Refraction if indicated

Provider Signature: _____ Date: _____

# ATHLETE WITH DISABILITIES SUPPLEMENT TO THE ATHLETE HISTORY

Minnesota State High School League

**Pages 2-5 of this document should be KEPT on file by the medical provider issuing the physical examination.**

Name: _____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

| | |
|---|---|
| 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? | Y / N |
| 7. Do you use any special brace or assistive device for sports? | Y / N |
| 8. Do you have any rashes, pressure sores, or other skin problems? | Y / N |
| 9. Do you have hearing loss? Do you use a hearing aid? | Y / N |
| 10. Do you have a visual impairment? | Y / N |
| 11. Do you use any special devices for bowel or bladder function? | Y / N |
| 12. Do you have burning or discomfort when urinating? | Y / N |
| 13. Have you had autonomic dysreflexia? | Y / N |
| 14. Have you ever been diagnosed as having a heat-related or cold-related illness? | Y / N |
| 15. Do you have muscle spasticity? | Y / N |
| 16. Do you have frequent seizures that cannot be controlled by medication? | Y / N |

**Explain "Yes" answers here.**

_____

_____

_____

**Please indicate whether you have ever had any of the following conditions:**

| | |
|---|---|
| Atlantoaxial instability | Y / N |
| Radiographic (x-ray) evaluation for atlantoaxial instability | Y / N |
| Dislocated joints (more than one) | Y / N |
| Easy bleeding | Y / N |
| Enlarged spleen | Y / N |
| Hepatitis | Y / N |
| Osteopenia or osteoporosis | Y / N |
| Difficulty controlling bowel | Y / N |
| Difficulty controlling bladder | Y / N |
| Numbness or tingling in arms or hands | Y / N |
| Numbness or tingling in legs or feet | Y / N |
| Weakness in arms or hands | Y / N |
| Weakness in legs or feet | Y / N |
| Recent change in coordination | Y / N |
| Recent change in ability to walk | Y / N |
| Spina bifida | Y / N |
| Latex allergy | Y / N |

**Explain "Yes" answers here.**

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____ Signature of parent or guardian: _____

Date: ____/____/_____

Adapted from *2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.*