

# PHYSICAL EXAMINATION INSTRUCTIONS

## I. Requirement of School Boards.

- A. Each governing board shall decide if the exam is to be repeated on an annual basis, on a biennial basis or triennial basis.
- B. Each governing board shall decide whether they want the doctors to evaluate sexual maturity based upon the Tanner Maturation Index. Please white-out item 13 on the Physical Exam form if the decision is NOT to use the Tanner Maturation Index.

## II. Requirements of Member Schools.

- A. Each member school shall make copies of the forms that must be completed by the parents and/or doctors in sufficient quantities to meet your needs.
- B. Member schools must keep on file the following:

- 1. A copy of the **PARENT PERMIT FORM**. This form must be submitted annually.
- 2. A copy of the **INITIAL PRE-PARTICIPATION HISTORY** report for each student who takes the comprehensive exam for the first time. This form must be made available to the medical examiner at the time the student takes his/her first physical exam.
- 3. A copy of the **INTERIM PRE-PARTICIPATION HISTORY** for each student must be submitted annually by the parents except on the very first occasion when the **INITIAL PRE-PARTICIPATION HISTORY** is required.

All questions on the **INTERIM PRE-PARTICIPATION HISTORY** form should be answered with the following in mind: **IN THE PAST YEAR:** Please explain any yes answers in the space provided on the form. Any yes answers may require a re-visit to the medical provider for re-certification of health. The parent/guardian signature denotes that the student is physically able to participate.

- 4. A copy of the comprehensive **PHYSICAL EXAMINATION** signed by either a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner.
- C. Member schools may commence scheduling physical exams as early as April 1 for the ensuing school year.

## III. Role of Doctors, Physician Assistant and Nurse Practitioners.

- A. The certification/signing of the physical exam form is reserved for only a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, a Physician Assistant or Nurse Practitioner. Stamping the name of a medical clinic or a medical association as a substitute for the authorized signature is unacceptable. All exams must be signed by authorized medical personnel as listed in paragraph two above.
- B. The examiner shall receive a copy of Instructions for conducting the orthopedic screening and other portions of the exam. The instruction sheet follows the other forms located in this section of this publication.
- C. The medical history form must be made available to the person(s) conducting the physical exam at the time the examination takes place.

# **SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION**

## **PHYSICAL EXAMINATION ITEMS TO BE EVALUATED**

### **Station 1 - Individual History**

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

### **Station 2 - Blood Pressure**

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75  
12 years and older 140/85

### **Station 3 - Vision (Snellen)**

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

### **Station 4 - Skin, Mouth, Eyes, Ears**

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

### **Station 5 - Chest**

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

### **Station 6 - Lymphatics, Abdomen, Genitalia**

Cervical or axillary adenopathy, organomegaly, absence of testicles, hernia, and Tanner maturation index.

### **Station 7 - Orthopedic**

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

### **Station 8 - Review**

Check all categories that apply.

- ☐ All Sports (collision, contact/endurance, other)
- ☐ Contact/Endurance Sports only due to
- ☐ Other Sports Only due to
- ☐ Sports Participation Not Recommended, due to
- ☐ Approval Withheld Pending evaluation for

**Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]**

# SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION ORTHOPEDIC SCREENING GUIDE

<b>Athletic Activity (Instructions)</b>	<b>Observation</b>
Stand Facing Examiner	General habitus; acromioclavicular joints
Look at ceiling, floor, over both shoulders; touch ears to shoulders	Cervical spine motion
Shrug shoulders (examiner resists)	Trapezius strength
Abduct shoulder 90 degrees (examiner resists at 90 degrees)	Deltoid strength
Full external rotation of arms	Shoulder motion
Flex and extend elbows	Elbow motion
Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists	Elbow and wrist motion
Spread fingers; make fist	Hand or finger motion and deformities
Tighten (contact) quadriceps; relax quadriceps	Symmetry and knee effusion; ankle effusion
"Duck walk" four steps (away from the examiner with buttocks on heels)	Hip, knee and ankle motion
Back to examiner; knees straight, touch toes	Shoulder symmetry; scoliosis, hip motion, hamstring tightness
Raise up on toes, raise heels	Calf symmetry, leg strength

---

**May require reflex hammer, tape measure, pin, and examination table.**

---

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for \_\_\_\_\_ GRADE \_\_\_\_\_  
Name (Please Print) 2010-11 School Year

who was born at \_\_\_\_\_  
City, Town, County, State

on \_\_\_\_\_ to compete in SDHSAA approved athletics for \_\_\_\_\_ High School  
Date of Birth

during the 2010-2011 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Parent or Legal Guardian

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.**

---

**INITIAL PRE-PARTICIPATION HISTORY**

**SEE REVERSE SIDE FOR  
HEALTH HISTORY QUESTIONNAIRE**

# INITIAL PRE-PARTICIPATION HISTORY

(This form must be completed prior to the taking of a physical examination.)

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(2010-11 School Year)

		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 non-prescription (over-the-counter) medicines or pills?		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you ever passed out or nearly passed out DURING exercise?		
6.	Have you ever passed out or nearly passed out AFTER exercise?		
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8.	Does your heart race or skip beats during exercise?		
9.	Has a doctor ever told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Does anyone in your family have a heart problem?		
13.	Has any family member or relative died of heart problems or of sudden death before age 50?		
14.	Does anyone in your family have Marfan Syndrome?		
15.	Have you ever spent the night in a hospital?		
16.	Have you ever had surgery?		
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game?		
18.	Have you had any broken or fractured bones or dislocated joints?		
19.	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?		
20.	Have you ever had a stress fracture?		
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22.	Do you regularly use a brace or assistive device?		
23.	Has a doctor ever told you that you have asthma or allergies?		
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.	Is there anyone in you family who has asthma?		
26.	Have you ever used an inhaler or taken asthma medicine?		
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28.	Have you had infectious mononucleosis (mono) within the last month?		
29.	Do you have any rashes, pressure sores, or		

		YES	NO
	other skin problems?		
30.	Have you had a herpes skin infection?		
31.	Have you ever had a head injury or concussion?		
32.	Have you been hit in the head and been confused or lost your memory?		
33.	Have you ever had a seizure?		
34.	Do you have headaches with exercise?		
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36.	Have you ever been unable to move your arms or legs after being hit or falling?		
37.	When exercising in the heat, do you have severe muscle cramps or become ill?		
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell anemia?		
39.	Have you had any problems with your eyes or vision?		
40.	Do you wear glasses or contact lenses?		
41.	Do you wear protective eyewear, such as goggles or a face shield?		
42.	Are you happy with your weight?		
43.	Are you trying to gain or lose weight?		
44.	Has anyone recommended you change your weight or eating habits?		
45.	Do you limit or carefully control what you eat?		
46.	Do you have any concerns that you would like to discuss with a doctor?		
47.	Are there other sports that you would like to participate in that were not approved at a previous examination?		

## FEMALES ONLY:

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 12 months?	_____	

Explain "Yes" answers here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(continue on front side of this form if necessary)

I do not know of any additional health reason which should keep this student from participating in interscholastic athletics. I certify that the answers to the above questions are true.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Parent or Guardian



**SOUTH DAKOTA HIGH SCHOOL  
ACTIVITIES ASSOCIATION  
PHYSICAL EXAMINATION FORM**

**Date Exam Expires:** \_\_\_\_\_

Check Appropriate Physical Exam Term:

\_\_\_\_Annual \_\_\_\_Biennial\_\_\_\_Triennial

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
CHECK ONE: \_\_\_\_ MALE \_\_\_\_ FEMALE (2010-11 School Year)

1. Blood pressure (sitting) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Repeat in 5 minutes, if elevated \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_.

2. Height \_\_\_\_\_

3. Weight \_\_\_\_\_

**Normal**

**Abnormal**

**COMMENTS**

4. Vision 20/\_\_\_\_\_(L) 20/\_\_\_\_\_(R)

5. Head

6. Mouth (dentures, braces?)

7. Eyes (contacts?)

8. Chest/lung

9. Heart

a. Heart sounds

b. Murmurs

c. pulse discrepancy (rad. vs fem.)

d. abnormal rhythm

NO \_\_\_\_\_

YES \_\_\_\_\_

YES \_\_\_\_\_

NO \_\_\_\_\_

YES \_\_\_\_\_

NO \_\_\_\_\_

10. Abdomen

a. liver or spleen enlargement

b. masses

YES \_\_\_\_\_

NO \_\_\_\_\_

YES \_\_\_\_\_

NO \_\_\_\_\_

11. Genitalia

a. hernias

b. testes

YES \_\_\_\_\_

NONE \_\_\_\_\_

12. Orthopedic

a. cervical spine

b. shoulder shrug

c. deltoid

d. arms/elbow

e. hands

f. hips

g. knees

h. ankles

i. Scoliosis

13. Tanner Maturation Index (Optional) Circle: I II III IV V

**SPORTS PARTICIPATION RECOMMENDED FOR:**

\_\_\_\_\_ All Sports: collision, contact/endurance, other

\_\_\_\_\_ Contact/Endurance Sports only due to

\_\_\_\_\_ Other Sports Only due to

\_\_\_\_\_ Sports Participation Not Recommended, due to

\_\_\_\_\_ Approval Withheld Pending evaluation for

**Definition:** [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

NAME OF EXAMINER \_\_\_\_\_ DATE \_\_\_\_\_

**NOTE:** The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for \_\_\_\_\_ GRADE \_\_\_\_\_  
Name (Please Print) 2010-11 SCHOOL YEAR  
who was born at \_\_\_\_\_ on \_\_\_\_\_  
City, Town, County, State Date of Birth

to compete in SDHSAA approved athletics for \_\_\_\_\_ High School during the 2010-2011 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.**

---

**INTERIM PRE-PARTICIPATION HISTORY**

(Used in conjunction with the Biennial/Triennial examination.)

**SEE REVERSE SIDE FOR  
HEALTH HISTORY QUESTIONNAIRE**

# INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(2010-11 School Year)

## IN THE PAST YEAR:

YES NO

1.	Has a doctor denied your participation in sports for any reason?		
2.	Do you have a new ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have new allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you passed out or nearly passed out DURING exercise?		
6.	Have you passed out or nearly passed out AFTER exercise?		
7.	Have you had discomfort, pain, or pressure in your chest during exercise?		
8.	Has your heart raced or skipped beats during exercise?		
9.	Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Have you spent the night in a hospital?		
13.	Have you had surgery?		
14.	Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?		
15.	Have you had any broken or fractured bones or dislocated joints?		
16.	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?		

YES NO

17.	Have you had a stress fracture?		
18.	Did a doctor tell you that you have asthma or allergies?		
19.	Have you started to cough, wheeze, or have difficulty breathing during or after exercise?		
20.	Have you used an inhaler or taken asthma medicine?		
21.	Have you lost a kidney, an eye, a testicle, or any other organ?		
22.	Do you have any new rashes, pressure sores, or other skin problems?		
23.	Have you had a new herpes skin infection?		
24.	Have you had a head injury or concussion?		
25.	Have you been hit in the head and been confused or lost your memory?		
26.	Have you had a seizure?		
27.	Have you experienced headaches with exercise?		
28.	Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
29.	Have you been unable to move your arms or legs after being hit or falling?		
30.	When exercising in the heat, did you have severe muscle cramps or become ill?		

Explain "Yes" answers here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(continue on front side of this form if necessary)

## RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

\_\_\_\_\_  
Date Signature of Parent

**This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.**

## **CONSENT FOR MEDICAL TREATMENT**

I am the \_\_\_\_\_ (Mother-Father-Legal Guardian)  
of \_\_\_\_\_, who participates in co-curricular activities  
for \_\_\_\_\_ High School. I hereby consent to any  
medical services that may be required while said child is under the supervision of an employee of  
\_\_\_\_\_ School District while on a school-sponsored  
activity and hereby appoint said employee to act on behalf in securing necessary medical services from  
any duly licensed medical provider.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Parent's Signature: \_\_\_\_\_

## **CONSENT OF CHILD**

I, \_\_\_\_\_, have read the above Consent form signed by  
my \_\_\_\_\_ (Mother-Father-Legal Guardian) and join  
with \_\_\_\_\_ (him/her) in the consent.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Student's Signature: \_\_\_\_\_

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT AND STUDENT CONSENT FORM**

School Year: \_\_\_\_\_ Name of High School: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains or more serious injuries such as the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, or on rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. ***If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.***

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

_____ Name of Student (Print Name)	_____ Student Signature
---------------------------------------	----------------------------

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for \_\_\_\_\_ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR  
INSPECTION AT THE SCHOOL**

## CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

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

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 20\_\_\_\_.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

**This form must be completed annually and must be available for inspection at the school**