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	Baseball	Badminton
Cheerleading	Field Events:	Bowling
Diving	❖ High Jump	Cross Country Running
Football	❖ Pole Vault	Dance Team
Gymnastics	Floor Hockey	Field Events:
Ice Hockey	Nordic Skiing	❖ Discus
Lacrosse	Softball	❖ Shot Put
Alpine Skiing	Volleyball	Golf
Soccer		Swimming
Wrestling		Tennis
		Track

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: ❖ Discus ❖ Shot Put Gymnastics*†	Alpine Skiing*† Wrestling*	
II. Moderate (20-50%)	Diving*†	Dance Team Football* Field Events: ❖ High Jump ❖ Pole Vault*† Synchronized Swimming† Track — Sprints	Basketball* Ice Hockey* Lacrosse* Nordic Skiing — Freestyle Track — Middle Distance Swimming†
I. Low (<20% MVC)	Bowling Golf	Baseball* Cheerleading Floor Hockey Softball* Volleyball	Badminton Cross Country Running Nordic Skiing — Classical Soccer* Tennis 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.

☐ **(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 ______________________________

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: _______________