



# MONTANA HIGH SCHOOL ASSOCIATION

---

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

May 2024

**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 completed for a 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 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 recently approved important additions to this form. Specifically, PHQ-4 questions concerning mental health of the student were added and the format of the document was updated.

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 History portion of the form together.
- The student and parent/guardian will sign the form.
- 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 completed MHSA Pre-participation Physical Exam form 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 or the MHSA sports medicine liaison, Greta Buehler.



## MHSAA CONFIDENTIAL ATHLETIC PREPARTICIPATION PHYSICAL EXAMINATION

Students must have a preparticipation physical examination completed yearly prior to the first practice of any sport. 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 MHSAA, parents/guardians may choose their own medical provider for their Physical Examination**. 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.** All information is to remain confidential.

### HISTORY FORM

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

**Athlete Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Parent/Guardian's Name:** \_\_\_\_\_ **Family Physician:** \_\_\_\_\_

**Date of examination:** \_\_\_\_\_ **Current school:** \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

\_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (i.e. medicines, pollens, food, stinging insects). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Health Questionnaire Version 4 (PHQ-4)**

*Over the last 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

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

<b>GENERAL QUESTIONS</b> (Explain "Yes" answers at the end of the form. Circle questions if you don't know the answer.)	YES	NO	<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?			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)?		
2. Has a provider ever denied or restricted your participation in sports for any reason?			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)?		
3. Do you have any ongoing medical issues or recent illness?			13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	YES	NO	<b>BONE AND JOINT QUESTIONS</b>	YES	NO
4. Have you ever passed out or nearly passed out during or after exercise?			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?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			15. Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			16. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
7. Has a doctor ever told you that you have any heart problems?			<b>MEDICAL QUESTIONS</b>	YES	NO
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.			17. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			18. Have you ever used an inhaler or taken asthma medicine?		
10. Have you ever had a seizure?			19. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		

MEDICAL QUESTIONS (CONTINUED)	YES	NO	ADDITIONAL INFORMATION
20. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			Explain any "Yes" responses to questions in the history sections below. _____ _____ _____ _____ _____ _____
21. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
22. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
23. Have you ever become ill while exercising in the heat?			
24. Do you or does someone in your family have sickle cell trait or disease?			
25. Have you had or do you have any problems with your eyes or vision?			
26. Have you ever had an eating disorder?			
27. Have you had infectious mononucleosis (mono) within the last Month?			
FEMALES ONLY	YES	NO	
28. Have you ever had a menstrual period?			
29. How old were you when you had your first menstrual period?			
30. When was your most recent menstrual period?			
31. How many periods have you had in the past 12 months?			

Name of Athlete (typed or printed): \_\_\_\_\_

Signature of Athlete: \_\_\_\_\_

**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.

Name of Parent/Guardian (typed or printed): \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Address: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Parent's Home Phone: \_\_\_\_\_ Parent's Cell Phone: \_\_\_\_\_ Parent's Work Phone: \_\_\_\_\_

**ALL INFORMATION IS TO REMAIN CONFIDENTIAL**



### PROVIDER'S PHYSICAL EXAMINATION FORM

Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

EXAMINATION: TO BE FILLED OUT BY MEDICAL PROVIDER ONLY		
Height: _____ Weight: _____		
Pulse: _____ BP: _____ / _____ Vision: R 20/_____ L 20/_____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N Pupils: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal		
MEDICAL (Please initial)	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata)		
Eyes/Ears/Nose/Throat (pupils equal, hearing)		
Lymph Nodes		
Heart (murmurs)		
Pulses (simultaneous femoral and radial)		
Lungs		
Abdomen		
Skin (HSV, MRSA, tinea corporis)		
Neurological		
Genitourinary (males only)		
MUSCULOSKELETAL (Please initial)	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (double-leg squat test, single-leg squat test, box drop or step drop test)		

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

\_\_\_\_\_

### CLEARANCE

- 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: \_\_\_\_\_