

# DELAWARE INTERSCHOLASTIC ATHLETIC ASSOCIATION

**Parents/Guardian: The DIAA pre-participation physical evaluation and consents form is a five page document. Pages one, two and four require your signature while page five is a reference for you to keep. This physical evaluation must be completed after May 1 of the current year playing sports and runs through June 30 of the following year.**

Athlete: \_\_\_\_\_ Phone: \_\_\_\_\_ School: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: (Please Print) \_\_\_\_\_

## PARENT/GUARDIAN CONSENTS

\_\_\_\_\_ Has my permission to participate in all interscholastic sports **not checked below**.  
(Name of Athlete)

**If you check any sport in this box it means the athlete will not be permitted to participate in that sport.**

Collision		Contact		Non-Contact	
<input type="checkbox"/> football	<input type="checkbox"/> ice hockey	<input type="checkbox"/> volleyball	<input type="checkbox"/> softball	<input type="checkbox"/> cross country	<input type="checkbox"/> tennis
<input type="checkbox"/> soccer	<input type="checkbox"/> boys' lacrosse	<input type="checkbox"/> field hockey	<input type="checkbox"/> baseball	<input type="checkbox"/> swimming	<input type="checkbox"/> golf
<input type="checkbox"/> wrestling		<input type="checkbox"/> basketball	<input type="checkbox"/> girls lacrosse	<input type="checkbox"/> track	<input type="checkbox"/> crew
		<input type="checkbox"/> squash		<input type="checkbox"/> cheerleading	

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed page 5, which is the list of items that protect against the loss of athletic eligibility, with said participant and I will retain that page for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities not checked above.  
**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_
  
2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.  
**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_
  
3. I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.  
**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_
  
4. By this signature, I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information maybe used for injury surveillance purposes.  
**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# DIAA Preparticipation Physical Evaluation

# HISTORY FORM

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

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

Personal physician \_\_\_\_\_

*In case of emergency, contact*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "YES" answers below.

Circle questions you don't know the answers to.

- |  | Yes  | No                       |
|--|--|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?                 | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?                                 | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?                            | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise?                                      | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise?                                       | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?                      | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?   | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply):                                    |  |                          |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> A heart murmur    |                          |
| <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> A heart infection |                          |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)                | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason?   | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem?   | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?         | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome?   | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital?   | <input type="checkbox"/>                   | <input type="checkbox"/> |
| 16. Have you ever had surgery?   | <input type="checkbox"/>                   | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:           | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> |

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? _____ |                          |                          |
| 49. How many periods have you had in the last 12 months? _____       |                          |                          |

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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# DIAA PRE-PARTICIPATION PHYSICAL EVALUATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_)  
 Vision R 20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_ Risk behaviors discussed: Y N  
 (diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary(males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
*Multiple-examiner set-up only +Having 3rd party present is recommended for the genitourinary exam			
Notes:			

**Please choose one of the following four (4) options:**

1. Cleared without restriction  
 2. Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 3. \*Not Cleared, but needs additional evaluation by (whom): \_\_\_\_\_  
 4. Not Cleared for either  All sports  Certain sports: \_\_\_\_\_  
 Reason: \_\_\_\_\_

**Please note any necessary equipment, medications, or restrictions for cleared athlete to play or practice:**

By this signature, I hereby state that I have performed a pre-participation examination in accordance with DIAA standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation) and certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I also agree that I have documented and signed any playing restrictions on the High School Athlete Medical Card (pg 4).

**HealthCare Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Printed Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*\*If Option 3 checked then Referred Physician needs to complete below:*

Cleared- no restriction  Cleared with the following restrictions: \_\_\_\_\_  
 Not Cleared for  All sports  Certain sports: \_\_\_\_\_

**Referred Physician Signature:** \_\_\_\_\_ **Print:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

## Section 1: CONTACT/PERSONAL INFORMATION

NAME: \_\_\_\_\_ SPORT: \_\_\_\_\_ SS#: \_\_\_\_\_

AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ (P) \_\_\_\_\_

Other authorized person to contact in case of emergency:

NAME: \_\_\_\_\_ PHONE(s): \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE(s): \_\_\_\_\_

Preference of Physician (and permission to contact if needed):

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL PREFERENCE: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP: \_\_\_\_\_ PHONE: \_\_\_\_\_

## Section 2: MEDICAL INFORMATION

MEDICAL ILLNESSES: \_\_\_\_\_

LAST TETANUS (mo/yr): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

(any medications that may be taken during competition require a physician's note)

PREVIOUS HEAD/NECK/BACK INJURY: \_\_\_\_\_

PREVIOUS HEAT-RELATED PROBLEMS: \_\_\_\_\_

PREVIOUS SIGNIFICANT INJURIES: \_\_\_\_\_

ANY OTHER IMPORTANT MEDICAL INFORMATION: \_\_\_\_\_

## Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section 4: Clearance for Participation

Cleared without restrictions

Cleared with the following restrictions:

Health Care Provider's Signature: \_\_\_\_\_ MD/DO, PA, NP Date: \_\_\_\_\_

**For office use only:** This card is valid from May 1, 20 \_\_\_\_\_ through June 30, 20 \_\_\_\_\_

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: \_\_\_\_\_ Name of ATC: \_\_\_\_\_

# Protect Your Athletic Eligibility

## **YOU ARE NOT ELIGIBLE:**

1. If you attend a high school and become 19 years of age before June 15. (Reg. 1009.2.1.1)
2. If you attend a junior high/middle school that terminates in the 8th grade and become 15 years of age before June 15. (Reg. 1008.2.1.1.1)
- \*3. If you are not legally enrolled at the school which you represent. (Reg. 1008.2.3.1 and Reg. 1009.2.3.1)
4. If you are not residing with your custodial parent(s), court appointed legal guardian(s), Relative Caregiver, or are a student 18 years of age or older and living in the attendance zone of the school you attend unless you are participating in the Delaware School Choice Program, attend a private school or are a boarding school student. **IF YOUR CUSTODIAL PARENT(S), LEGAL GUARDIAN(S) OR RELATIVE CAREGIVER(S) RELOCATES TO A DIFFERENT ATTENDANCE ZONE, YOU MUST NOTIFY YOUR ATHLETIC DIRECTOR IMMEDIATELY.** (Reg. 1008.2.2.1 and Reg. 1009.2.2.1)
- \*5. If you were absent unexcused or absent due to illness or injury; have been suspended (in-school or out-of-school); or have been assigned to homebound instruction or an alternative school for disciplinary reasons. (Reg. 1008.2.3.4 and 1008.2.3.5 Reg. 1009.2.3.5 and 1009.2.3.6)
6. If you failed to complete the preceding semester for reasons other than personal illness or injury. (Reg. 1008.2.3.6; Reg. 1009.2.3.7)
- \*7. If you do not pursue a regular course of study and pass at least five credits per marking period (equivalent of four credits in junior high/middle school), two credits of which must be in the areas of Mathematics, Science, English, or Social Studies. **IF YOU ARE A SENIOR, YOU MUST PASS ALL COURSES WHICH SATISFY AN UNMET GRADUATION REQUIREMENT.** (Reg. 1008.2.6.; Reg. 1009.2.6.1)
8. If you transferred and have not been in regular attendance at your receiving school for at least 90 school days unless the transfer was the result of a change in residence by you and your custodial parent(s) or court appointed legal guardian(s) from the attendance zone of the sending school to the attendance zone of the receiving school or you transferred after the end of the previous academic year and completed registration at your receiving school before the first student day of the current academic year. (Reg. 1008.2.4 and Reg. 1009.2.4)
9. If you participated in the Delaware School Choice Program during the previous academic year and transferred to your “home school” for the current academic year without completing your two-year commitment or receiving a release from the sending school. (Reg. 1008.2.3.3; Reg. 1009.2.3.4)
10. If you participated in the Delaware School Choice Program during the previous academic year and transferred to another “choice school” for the current academic year unless you are playing a sport not sponsored by the sending school. (Reg. 1008.2.4.6.1; Reg. 1009.2.4.7.1)
11. If you reached the age of majority (18), occupied a residence in a different attendance zone than your custodial parent(s) or court appointed legal guardian(s), and have not been in regular attendance at your receiving school for at least 90 school days unless you are participating in the Delaware School Choice Program and your application was properly submitted prior to your change of residence. (Reg. 1009.2.2.1.7)
12. If you attend a high school and more than four years has elapsed since you first entered 9th grade, or more than five years has elapsed since you just entered 8<sup>th</sup> grade in schools with 8<sup>th</sup> grade eligibility for high school sports. (Reg. 1009.2.7.1 and 2.7.2.1)
13. **If you attend a junior high/middle school in which only grades 7-8 are permitted to participate in interscholastic athletics and more than two years has elapsed since you first entered 7th grade. (Reg. 1008.2.7.1)**
14. **If you attend a junior high/middle school in which grades 6-8 are permitted to participate in interscholastic athletics and more than three years has elapsed since you first entered 6th grade. (Reg. 1008.2.7.2)**
15. If you have played on or against a professional team or have accepted cash or a cash equivalent (savings bond, certificate of deposit, etc.); a merchandise item(s) with an aggregate retail value of more than \$150; a merchandise discount; a reduction or waiver of fees; a gift certificate or other valuable consideration for athletic participation. (Reg. 1009.2.5.1.4 and 2.5.1.5)
16. If you have used your athletic status to promote a commercial product or service in an advertisement or personal appearance. (Reg. 1009.2.5.1.7)
17. If you have not received a physical examination from a licensed physician (M.D. or D.O.), a certified nurse practitioner or a certified physician’s assistant on or after **May 1** and written consent from your custodial parent(s) or court appointed legal guardian(s) to participate in interscholastic athletics is not on file in the school office. (Reg. 1009.3.1.1.1 and Reg. 1008.3.1.1)
18. If you participate in an all-star game not approved by DIAA before you graduate from high school. (Reg. 1009.5.4)
19. If you are a foreign exchange student not participating in a two-semester program listed by the Council on Standards for International Educational Travel (CSIET). (Reg. 1009.2.8.1.2)
20. If you are an international student not in compliance with all DIAA regulations including Reg. 1009.2.2 residency requirements. (Reg. 1009.2.8.2)

**\*IF YOU ARE NOT IN COMPLIANCE WITH THESE REQUIREMENTS, YOU MAY NOT PRACTICE, SCRIMMAGE OR PLAY IN A GAME.**

NOTE: Consult with your coach, athletic director, or principal for information concerning additional eligibility requirements.