MSHSL ANNUAL SPORTS HEALTH QUESTIONNAIRE

DATE ____ / ____ / ________

Name_________________________________ Age  ____    Birth Date ___ / _____ / ______

Grade_________________________________ School __ Sport(s) ______

Address ___________________________________________________________________________________

Phone ___________________ Date of Last Sports Qualifying Physical Exam (SQPE) ___ / ____ / _______

Check Yes or No boxes for each question or Circle question numbers for which you cannot answer.

IN THE LAST YEAR, since your last complete Sports Qualifying Physical Exam with your physician or your Year 2 Annual
Health Questionnaire, HAVE YOU HAD ANY CHANGES TO THE FOLLOWING QUESTIONS:

YES NO

1. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to
return to sports? ............................................................. ..........

IMPORTANT HEART HEALTH QUESTIONS ABOUT YOU IN THE LAST YEAR

2. In the last year, have you passed out or nearly passed out during or after exercise? ....................

3. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise? ........

4. In the last year, does your heart race or skip beats (irregular beats) during exercise? ......................

5. In the last year, do you get light-headed or feel more short of breath than expected during exercise? ....

6. In the last year, have you had an unexplained seizure? .................................................................

IMPORTANT HEART HEALTH QUESTIONS ABOUT YOUR FAMILY IN THE LAST YEAR

7. In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent
reason? ...................................................................................................................

8. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained
sudden death before age 35 (including an unexplained drowning or an unexplained car accident)? ...........

9. In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near
drowning? ............................................................................................................

10. In the last year, has anyone in your immediate family under age 35 had a heart problem, pacemaker, or implanted
defibrillator? ...........................................................................................................

MEDICAL RISK QUESTIONS IN THE LAST YEAR

12. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches,
concentration problems or memory problems? .................................................................................

Parents or Legal Guardians: Please note below any health concerns, medications, or allergies that may be important
for the coaches or athletic/activities director to know.

________________________________________________________________________________________
________________________________________________________________________________________

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that
the answers to the above questions are true and accurate and I approve participation in athletic activities.

___________________________________  ___________________________  __________
Parent or Legal Guardian Signature        Athlete Signature       Date

Updated: April 22, 2021
Supplemental Mental Health Screening Questions

Students: The following questions are optional. Based upon your responses, school staff may follow up for support.

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(If the sum of responses to questions 1 & 2 or 3 & 4 are ≥3, please see your provider)


Revised 4/9/2021