PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This MEDICAL HISTORY FORM must be completed annually by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event. Sex Student's Name: (print) ____Age___ Date of Birth Address Phone School Grade Personal Physician Phone In case of emergency, contact: Name Relationship Phone (H) (W) Explain "Yes" answers in the box below**. Circle questions you don't know the answers to. Yes No Yes No 1 Have you had a medical illness or injury since your last check Have you ever gotten unexpectedly short of breath with 13. п п exercise? up or physical? 2. Have you been hospitalized overnight in the past year? Do you have asthma? П П Do you have seasonal allergies that require medical treatment? Have you ever had surgery? п 3. Have you ever had prior testing for the heart ordered by a Do you use any special protective or corrective equipment or 14. physician? devices that aren't usually used for your activity or position Have you ever passed out during or after exercise? (for example, knee brace, special neck roll, foot orthotics, Have you ever had chest pain during or after exercise? retainer on your teeth, hearing aid)? Do you get tired more quickly than your friends do during 15. Have you ever had a sprain, strain, or swelling after injury? exercise? Have you broken or fractured any bones or dislocated any Have you ever had racing of your heart or skipped heartbeats? joints? Have you had high blood pressure or high cholesterol? Have you had any other problems with pain or swelling in Have you ever been told you have a heart murmur? muscles, tendons, bones, or joints? Has any family member or relative died of heart problems or of If yes, check appropriate box and explain below: sudden unexpected death before age 50? Has any family member been diagnosed with enlarged heart, □ Elbow Hip Head (dilated cardiomyopathy), hypertrophic cardiomyopathy, long Neck Forearm Thigh QT syndrome or other ion channelpathy (Brugada syndrome, Back Wrist Knee etc), Marfan's syndrome, or abnormal heart rhythm? Shin/Calf Chest Hand Have you had a severe viral infection (for example, Shoulder Finger Ankle myocarditis or mononucleosis) within the last month? □ Foot Upper Arm Has a physician ever denied or restricted your participation in п п 16. Do you want to weigh more or less than you do now? П П activities for any heart problems? 17 Do you feel stressed out? п Have you ever had a head injury or concussion? 18. Have you ever been diagnosed with or treated for sickle cell Have you ever been knocked out, become unconscious, or lost trait or sickle cell disease? your memory? Females Only If yes, how many times? 19. When was your first menstrual period? When was your last concussion? When was your most recent menstrual period? How severe was each one? (Explain below) How much time do you usually have from the start of one period to the start of Have you ever had a seizure? another? Do you have frequent or severe headaches? How many periods have you had in the last year? Have you ever had numbness or tingling in your arms, hands, What was the longest time between periods in the last year? legs or feet? Males Only Have you ever had a stinger, burner, or pinched nerve? 20. Do you have two testicles? 5. Are you missing any paired organs? 21. Do you have any testicular swelling or masses? Are you under a doctor's care? 6. An electrocardiogram (ECG) is not required. I have read and understand the Are you currently taking any prescription or non-prescription П 7. information about cardiac screening on the UIL Sudden Cardiac Arrest (over-the-counter) medication or pills or using an inhaler? Awareness Form. By checking this box, I choose to obtain an ECG for my 8. Do you have any allergies (for example, to pollen, medicine, student for additional cardiac screening. I understand it is the responsibility of food, or stinging insects)? my family to schedule and pay for such ECG. 9. Have you ever been dizzy during or after exercise? EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? 11. Have you ever become ill from exercising in the heat? 12. Have you had any problems with your eyes or vision? It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs. If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the

school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Parent/Guardian Signature:

Date:

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in ULL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, **PERFORMANCE** OR CONTEST BEFORE, DURING OR AFTER SCHOOL. *For School Use Only:*

This Medical History Form was reviewed by: Printed Name

Student Signature:

Date

Signature

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name		Sex	Age	Date of Birth		
Height	Weight	% Body fat (optional)	Pulse	BP	/ (brachial bloc	/,) od pressure while sitting
Vision: R 20/	L 20/	Corrected: \Box Y	□ N	Pupils:	Equal	□ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It *must* be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. * *Local district policy may require an annual physical exam.*

	NORMAL	ABNORMAL FINDINGS	INITIALS*		
MEDICAL					
Appearance					
Eyes/Ears/Nose/Throat					
Lymph Nodes					
Heart-Auscultation of the heart in					
the supine position.					
Heart-Auscultation of the heart in					
the standing position.					
Heart-Lower extremity pulses					
Pulses					
Lungs					
Abdomen					
Genitalia (males only)					
Skin					
Marfan's stigmata (arachnodactyly,					
pectus excavatum, joint					
hypermobility, scoliosis)					
MUSCULOSKELETAL					
Neck					
Back					
Shoulder/Arm					
Elbow/Forearm					
Wrist/Hand					
Hip/Thigh					
Knee					
Leg/Ankle					
Foot					

*station-based examination only

CLEARANCE

□ Cleared

Cleared after completing evaluation/rehabilitation for:

Not cleared for: ______ Reason: ______

Recommendations:

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.

____Reason: ____