SPORTS PHYSICALS

For All School Activities

Houston Methodist continues to safely provide care for all of our patients in the most appropriate setting possible. We are offering sports physicals at the following dates and locations:

April 5: Wheeler Fieldhouse
16325 Lexington Blvd.
Sugar Land, TX 77479
5-8 p.m.

April 19: Ridge Point High School
500 Waters Lake Blvd.
Missouri City, TX 77459
3-6 p.m.

April 26: Bush High School
6706 FM 1464
Richmond, TX 77407
3-6 p.m.

May 3: Hopson Fieldhouse
3335 Hurricane Ln.
Missouri City, TX 77459
5-8 p.m.

May 10: Austin High School
3434 Pheasant Creek Dr.
Sugar Land, TX 77498
5-8 p.m.

July 29: Houston Methodist Orthopedics & Sports Medicine
16811 Southwest Fwy.
Sugar Land, TX 77479
9 a.m. – Noon

Aug. 10: Hopson Fieldhouse
3335 Hurricane Ln.
Missouri City, TX 77459
6-8 p.m.

Cost: $20 (cash only)
For more information, please call **281.634.1914**.

DON'T FORGET:

- Wear light, comfortable clothing
- Bring glasses or wear contacts, if you have corrected vision
- Please bring your school physical form with medical history completed
- Please bring signed physical consent form

Please go to **houstonmethodist.org/athlete** to access these forms online.

HOUSTON Methodist®
ORTHOPEDICS & SPORTS MEDICINE

16811 Southwest Fwy.
Sugar Land, TX 77479
281.275.0447

032023

HOUSTON Methodist℠
ORTHOPEDICS & SPORTS MEDICINE

Please Print in Box

School:_____

Student Name:_____

Confirmation of Understanding of Limited Scope and Purpose of the Extra-Curricular/Co-Curricular Pre-Participation Physical Exams

I, _____, (Print Parent/Legal Guardian Name) am aware that my child/ward, _____ (Print Child's Name), will attend an event providing pre-participation physical exams for student athletes at _____ on _____, ____, 20___ ("the event"). The event is sponsored and provided by Houston Methodist ("Houston Methodist") for the sole purpose of clearing students for participation in extra-curricular/co-curricular programs. The screening physical exam will be performed by volunteer healthcare providers. By signing this form, I am confirming I understand and agree to the following:

- **I consent to the extra-curricular/co-curricular physical exam for the above-named child.**
- This is **NOT** a comprehensive physical exam and should not take the place of routine medical care; I understand that this is a **screening physical for clearance for participation in extra-curricular/co-curricular activities ONLY;**
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- I understand that my child may need additional testing before/he can be cleared for participation in athletic activities and it is my sole responsibility to obtain such additional testing or medical care: I understand that if it is determined that my child needs additional medical treatment; I will be notified of any such recommendation. I understand that a limited number of non-invasive tests may be available and performed at the event for my convenience; **I consent to any and all additional non-invasive testing as deemed necessary by the screening physician during the event without notification to me prior to the testing;** and
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event. This consent is valid for 180 days and I understand that I may revoke this consent at any time. I understand that the information released may not be protected under the law once it is disclosed and may be subject to re-disclosure by the Recipient.

_____

Parent/Guardian's Signature Date

RELEASE FROM LIABILITY AND INDEMNIFICATION

I hereby release, waive, discharge and covenant not to sue Houston Methodist and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the extra-curricular/co-curricular Physical Examination Event.

I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in the Release.

_____

Parent/Guardian's Signature Date

☐ I would like to stay connected with Houston Methodist on upcoming events, health tips and newsletters.

Please Print

Parent Name:_____

Parent Email Address:_____

Parent Address:_____

City:_____ State:_____ Zip:_____

2.1.2202

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

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.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

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. ***Student will be participating in: ___ATHLETICS ___Band/Fine Arts ___ROTC***

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
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?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

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

Student Signature: _____ 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 UIL 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 _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ 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: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____Place Office Stamp Here:

Phone Number: _____

Signature: _____

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.