

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.

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 JROTC

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

- 13. Have you ever gotten unexpectedly short of breath with exercise? Yes No
Do you have asthma? Yes No
Do you have seasonal allergies that require medical treatment? Yes No
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)? Yes No
15. Have you ever had a sprain, strain, or swelling after injury? Yes No
Have you broken or fractured any bones or dislocated any joints? Yes No
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No
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? Yes No
17. Do you feel stressed out? Yes No
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? Yes No

Females Only I choose not to provide written information on Question 19 but will discuss with a medical professional:
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 I choose not to provide written information on Question 20 but will discuss with a medical professional:
20. Are you missing a testicle? \_\_\_\_\_
Do you have any testicular swelling or masses? \_\_\_\_\_

OPTIONAL: An electrocardiogram (ECG) is not required. By marking this box, I choose to obtain an ECG for my student. I understand it is the responsibility of my family to schedule and pay for such an ECG. I have read and understood the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form.

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*
<b>MEDICAL</b>			
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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

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: (REQUIRED)**

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.