

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.

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
4. Have you ever had prior testing for the heart ordered by a physician? Yes No
5. Have you ever passed out during or after exercise? Yes No
6. Have you ever had chest pain during or after exercise? Yes No
7. Do you get tired more quickly than your friends do during exercise? Yes No
8. Have you ever had racing of your heart or skipped heartbeats? Yes No
9. Have you had high blood pressure or high cholesterol? Yes No
10. Have you ever been told you have a heart murmur? Yes No
11. Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes No
12. 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
13. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes No
14. Has a physician ever denied or restricted your participation in activities for any heart problems? Yes No
15. Have you ever had a head injury or concussion? Yes No
16. Have you ever been knocked out, become unconscious, or lost your memory? Yes No
17. If yes, how many times? _____
18. When was your last concussion? _____
19. How severe was each one? (Explain below)
20. Have you ever had a seizure? Yes No
21. Do you have frequent or severe headaches? Yes No
22. Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes No
23. Have you ever had a stinger, burner, or pinched nerve? Yes No
24. Are you missing any paired organs? Yes No
25. Are you under a doctor's care? Yes No
26. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? Yes No
27. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Yes No
28. Have you ever been dizzy during or after exercise? Yes No
29. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes No
30. Have you ever become ill from exercising in the heat? Yes No
31. Have you had any problems with your eyes or vision? Yes No
32. Have you ever gotten unexpectedly short of breath with exercise? Yes No
33. Do you have asthma? Yes No
34. Do you have seasonal allergies that require medical treatment? Yes No
35. 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
36. Have you ever had a sprain, strain, or swelling after injury? Yes No
37. Have you broken or fractured any bones or dislocated any joints? Yes No
38. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No
39. If yes, check appropriate box and explain below:
40. Head, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Foot, Hip, Thigh, Knee, Shin/Calf, Ankle
41. Do you want to weigh more or less than you do now? Yes No
42. Do you feel stressed out? Yes No
43. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? Yes No
44. Females Only
45. When was your first menstrual period? _____
46. When was your most recent menstrual period? _____
47. How much time do you usually have from the start of one period to the start of another? _____
48. How many periods have you had in the last year? _____
49. What was the longest time between periods in the last year? _____
50. Males Only
51. Do you have two testicles? _____
52. Do you have any testicular swelling or masses? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**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: _____

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.