

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-11-06

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: _____ 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 on an additional sheet. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 5, 7, 11, or 17 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

| | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip | | |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh | | |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee | | |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle | | |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot | | |
| Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Record the dates of your most recent immunizations (shots) for: | | |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ Measles _____ | | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ Chickenpox _____ | | |
| If yes how many times? _____ When was the last concussion? _____ | | | 17. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain below) _____ | | | Females Only | | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 18. When was your first menstrual period? _____ | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____ | | |
| 9. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> | An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question five 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. | | |
| Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high 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 athletic competition, 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: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)
 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 athletic participation and again prior to first and third years of high school athletic 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 | | | |
| 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 games/matches.