**Student ID #**

**X**

***This form must be on file prior to participation in any practice or performance before, during or after school.***

**Student Name LAST Student Name FIRST Grade 19-20 school year Date of Birth**

**Student Address (Street, City, Zip Code) Student Phone Age Sex**

***In case of Emergency contact:***

**Name Relationship Phone Cell Phone**

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.

**Explain “Yes” answers in the box below\*\***

**Circle questions to which you do not know the answer**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Yes No |  |  |  | Yes No |
| **1** | Have you had a medical illness or injury since your last check up or sports physical? | [ ]  [ ]  |  | **13** | Have you ever gotten unexpectedly short of breath with exercise?Do you have Asthma? | [ ]  [ ] [ ]  [ ]  |
| **2** | Have you been hospitalized overnight in the past year?  | [ ]  [ ]  |  |  | **\* If yes, complete both sides of the Asthma Action Form** |  |
|  | Have you ever had surgery?  | [ ]  [ ]  |  |  | Do you have an inhaler? | [ ]  [ ]  |
| **3** | Have you ever had prior testing for the heart ordered by a physician? | [ ]  [ ]  |  |  | Do you have seasonal allergies that require medical treatment? | [ ]  [ ]  |
|  | 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? | [ ]  [ ] [ ]  [ ] [ ]  [ ]  |  | **14** | 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)? | [ ]  [ ]  |
|  | Have you ever had racing of your heart or skipped heartbeats? | [ ]  [ ]  |  | **15** | Have you ever had a sprain, strain, or swelling after injury? | [ ]  [ ]  |
|  | Have you had high blood pressure or high cholesterol? | [ ]  [ ]  |  |  | Have you broken or fractured any bones or dislocated any joints? | [ ]  [ ]  |
|  | Have you ever been told you have a heart murmur? | [ ]  [ ]  |  |  | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | [ ]  [ ]  |
|  | Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | [ ]  [ ]  |  |  | If yes, check appropriate box and explain below. |  |
|  | 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)? | [ ]  [ ]  |  |  |

|  |  |  |
| --- | --- | --- |
| [ ]  Neck | [ ]  Forearm | [ ]  Thigh |
| [ ]  Back | [ ]  Wrist | [ ]  Knee |
| [ ]  Chest | [ ]  Hand | [ ]  Shin/Calf |
| [ ]  Shoulder | [ ]  Finger | [ ]  Ankle |
| [ ]  Upper Arm |  | [ ]  Foot |

 |  |
|  | 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 sports for any heart problems? | [ ]  [ ]  |  | **16** | Do you want to weigh more or less than you do now? | [ ]  [ ]  |
| **4** | Have you ever had a head injury or concussion? | [ ]  [ ]  |  |  | Do you lose weight regularly to meet weight requirements for your sport? | [ ]  [ ]  |
|  | Have you ever been knocked out, become unconscious, or lost your memory? | [ ]  [ ]  |  | **17** | Do you feel stressed out? | [ ]  [ ]  |
|  | If yes, how many times?  |   |  | **18** | Have you ever been diagnosed with or treated for sickle cell trait or sickle cell diseases? | [ ]  [ ]  |
|  | When was the last concussion? | [ ]  [ ]  |  |  | ***Females only*** |  |
|  | How severe was each one? (Explain below) |  |  | **19** | When was your first menstrual period? |  |
|  | Have you ever had a seizure? | [ ]  [ ]  |  |  | When was your most recent menstrual period? |  |
|  | Do you have frequent or severe headaches? | [ ]  [ ]  |  |  | How much time do you usually have from the start of one period to the start of another? |  |
|  | Have you ever had numbness or tingling in your arms, hands, legs, or feet? | [ ]  [ ]  |  |  | How many periods have you had in the last year? |  |
|  | Have you ever had a stinger, burner, or pinched nerve? | [ ]  [ ]  |  |  | What was the longest time between periods in the last year? |  |
| **5** | Are you missing any paired organs? | [ ]  [ ]  |  | **An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions 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 additional sheet if necessary) |
| **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? | [ ]  [ ]  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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 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**

**X**

**X**

 **Student Signature: Parent/Guardian Signature: Date:**

 **Any yes answer to questions, 1, 2, 3, 4, 5 or 6, may require further medical evaluation, which may include a physical exam. The written clearance from a Physician, Physician Assistant, Chiropractor, or Nurse Practitioner is required before any participation in UIL events.**

 **PRE-PARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION - BAND**

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** |  |  |  |
| Appearances |  |  |  |
| 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/Hand |  |  |  |
| Hip/Thigh |  |  |  |
| Knee |  |  |  |
| Leg/Ankle |  |  |  |
| Foot |  |  |  |
|  |  |  |  |

\*station-based examination only

[ ] Cleared

[ ] Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Not cleared for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Examination must be performed and signed on or after June 1, 2019 to be valid.

*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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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