School _____ Sport _____ Student ID _____

PHYSICALS MUST BE COMPLETED AFTER APRIL 1, 2018

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

Student Name:_____ **Grade:**_____ **Date of Birth:**_____/_____/_____

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 conditions which would make it hazardous to participate in an athletic event. *Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation.*

Question / Circle questions you don't know the answers to.	Yes	No	Explain any "Yes" Answers Here
1. Have you had a medical illness or injury since your last check up or sports 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 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 sports 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 the last concussion?_____How severe was each one? **explain**			
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?			
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 sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)			
15. Have you ever had a sprain, or 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 below and explain. ☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Knee ☐ Chest ☐ Hand ☐ Shin/Calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Foot ☐ Back ☐ Wrist ☐ Upper Arm			
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 cell disease?			

FEMALES ONLY:

When was your first menstrual period?_____ When was your most recent 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:

Do you have two testicles? _____ 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.

If, between the date of execution of this form 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 herby 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 student in question to penalties by the UIL.

Student Signature:_____ **Parent/Guardian Signature:**_____

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____Date_____Signature_____

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PREPARTICIPATION PHYSICAL EVALUATION- PHYSICAL EXAMINATION

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 any yes answers to specific questions on the student's Medical History Form. *** Local district policy requires a physical exam per school year not calendar year.**

Height_____ Weight_____ %Body fat (optional)_____ Pulse_____ BP___/___(___/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____

	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)			

Examiner Signature:_____

*station-based examination only

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Foreman			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Examiner Signature:_____

*station-based examination only

CLEARANCE Please Check or Circle One:

☐ Cleared

☐ Cleared after evaluations/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 Exam_____

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.

PHYSICALS DATED BEFORE APRIL 1, 2018 WILL NOT BE ACCEPTED.