

STUDENT NAME (LAST, FIRST) \_\_\_\_\_  
 SPORT(S): \_\_\_\_\_

DOB \_\_\_\_\_ GRADE(2018-19): \_\_\_\_\_ School: \_\_\_\_\_  
 GENDER: (MALE/FEMALE)

**PREPARTICIPATION PHYSICAL EVALUATION-MEDICAL HISTORY**

Please answer each question by circling "YES" or "NO".

1. Have you had a medical illness or injury since your last check up or sports physical? YES NO
2. Have you been hospitalized overnight in the past year? YES NO  
 Have you ever had surgery? YES NO
3. Have you ever passed out during or after exercise? YES NO  
 Have you ever had chest pain during or after exercise? YES NO  
 Do you get tired more quickly than your friends do during exercise? YES NO  
 Have you ever had racing of your heart or skipped heartbeats? YES NO  
 Have you had high blood pressure or high cholesterol? YES NO  
 Have you ever been told you have a heart murmur? YES NO  
 Has any family member or relative died of heart problems or of sudden unexpected death before age 50? YES NO
- 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
- Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO
- Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO
4. Have you ever had a head injury or concussion? YES NO  
 Have you ever been knocked out, become unconscious, or lost your memory? YES NO  
 If yes, how many times? \_\_\_\_\_ When was the last concussion? \_\_\_\_\_  
 How severe was each one? (Explain below) \_\_\_\_\_  
 Have you ever had a seizure? YES NO  
 Do you have frequent or severe headaches? YES NO  
 Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO  
 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 allergies (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 (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 sport 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  
 Do you lose weight regularly to meet weight requirements for your sport? 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**

97. 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? \_\_\_\_\_  
 \*Explain "Yes" answers here: A "yes" on questions 1, 2, 3, 4, 5, or 6 requires a 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.

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 OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

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 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.

Student Signature \_\_\_\_\_

Parent Signature: \_\_\_\_\_

**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 yes answers to specific questions on the students Medical History Form. **The PISD requires annual completion of this form.**

Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_  
 ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_  
 Unequal \_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
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 pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE (Please check one)**

- Cleared (No restrictions)
- 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, 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.

Physician Name (print/type): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<p><b>FOR SCHOOL USE ONLY:</b>          This medical history form was reviewed by:</p> <p>Printed Name: _____</p> <p>Signature: _____ Date: _____</p>
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