Athlete Contact Information

Last Name First Name Middle

Date of Birth Gender School Grade

Home Telephone Number | Student Cell Phone Number

Street Address (No P.O. Boxes) | City | Zip Code

Male Parent/Guardian's Name | Employment / Bus. Phone Number | Cell Phone Number

Female Parent/Guardian's Name | Employment / Bus. Phone Number | Cell Phone Number

Emergency Contact Name (Non-Parent) | Home Telephone Number | Alternate Contact Number

STUDENT NAME (LAST, FIRST)___________________________________
SPORT(S):____

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 channelpathy(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,gamesormatches)______________________________________
____

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, or advanced practice nurse.

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 Signature:_________________________________

ID#____________ **GRADE**:_____________**School:**_______________
GENDER: (MALE/FEMALE)

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 yest answers to specific questions on the students Medical History Form. The **LISD 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 FINIDINGS
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		
MUSCULOSKELETAL		
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: _______________

FOR SCHOOL USE ONLY:
This medical history form was reviewed by:

Printed Name:_____________________________________

Signature:____________________________**Date:**________