

## PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

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: (print) \_\_\_\_\_ 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 in the box below\*\*. Circle questions you don't know the answers to.

|                                                                                                                                                                                                                                    | 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"/> | 13. Have you ever gotten unexpectedly short of breath with exercise?                                                                                                                                                            | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 2. Have you been hospitalized overnight in the past year?                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma?                                                                                                                                                                                                             | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever had surgery?                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment?                                                                                                                                                                  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 3. Have you ever had prior testing for the heart ordered by a physician?                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | 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)? | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever passed out during or after exercise?                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had a sprain, strain, or swelling after injury?                                                                                                                                                               | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever had chest pain during or after exercise?                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints?                                                                                                                                                                | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Do you get tired more quickly than your friends do during 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 had racing of your heart or skipped heartbeats?                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below:                                                                                                                                                                                |                                  |                                    |
| Have you had high blood pressure or high cholesterol?                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head                                                                                                                                                                                                   | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| Have you ever been told you have a heart murmur?                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck                                                                                                                                                                                                   | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| 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"/> Back                                                                                                                                                                                                   | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest                                                                                                                                                                                                  | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder                                                                                                                                                                                               | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| Has a physician ever denied or restricted your participation in sports for any heart problems?                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm                                                                                                                                                                                              | <input type="checkbox"/> Foot    |                                    |
| 4. Have you ever had a head injury or concussion?                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you want to weigh more or less than you do now?                                                                                                                                                                          | <input type="checkbox"/>         | <input type="checkbox"/>           |
| Have you ever been knocked out, become unconscious, or lost your memory?                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you feel stressed out?                                                                                                                                                                                                   | <input type="checkbox"/>         | <input type="checkbox"/>           |
| If yes, how many times? _____                                                                                                                                                                                                      |                          |                          | 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?                                                                                                                                  | <input type="checkbox"/>         | <input type="checkbox"/>           |
| When was your last concussion? _____                                                                                                                                                                                               |                          |                          | <i>Females Only</i>                                                                                                                                                                                                             |                                  |                                    |
| How severe was each one? (Explain below)                                                                                                                                                                                           |                          |                          | 19. When was your first menstrual period? _____                                                                                                                                                                                 |                                  |                                    |
| Have you ever had a seizure?                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____                                                                                                                                                                               |                                  |                                    |
| Do you have frequent or severe headaches?                                                                                                                                                                                          | <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 numbness or tingling in your arms, hands, legs or feet?                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____                                                                                                                                                                           |                                  |                                    |
| Have you ever had a stinger, burner, or pinched nerve?                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____                                                                                                                                                               |                                  |                                    |
| 5. Are you missing any paired organs?                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <i>Males Only</i>                                                                                                                                                                                                               |                                  |                                    |
| 6. Are you under a doctor's care?                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you have two testicles? _____                                                                                                                                                                                            |                                  |                                    |
| 7. 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"/> | 21. Do you have any testicular swelling or masses? _____                                                                                                                                                                        |                                  |                                    |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                 |                                  |                                    |
| 9. Have you ever been dizzy during or after exercise?                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                 |                                  |                                    |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                 |                                  |                                    |
| 11. Have you ever become ill from exercising in the heat?                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                 |                                  |                                    |
| 12. Have you had any problems with your eyes or vision?                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                 |                                  |                                    |

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.

\*\*EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

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.

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: \_\_\_\_\_

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.

For School Use Only:

This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

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 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* |
|--------------------------------------------------------------------------------------|--------|-------------------|-----------|
| <b>MEDICAL</b>                                                                       |        |                   |           |
| 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) |        |                   |           |
| <b>MUSCULOSKELETAL</b>                                                               |        |                   |           |
| 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.