

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

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. 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**

| | 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 passed out during or after exercise? | <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 had chest pain 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"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <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 had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| 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"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| 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"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| 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"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| 4. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <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"/> |
| If yes, how many _____ When was the last concussion? | | | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain below) | | | 17. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | Females Only | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | 19. When was your first menstrual period? | | _____ |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? | | _____ |
| 5. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? | | _____ |
| 6. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? | | _____ |
| 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"/> | What was the longest time between periods in the last year? | | _____ |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <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. | | |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | **EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): | | |
| 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"/> | | | |

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: _____

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* |
|--|--------|-------------------|-----------|
| 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) | | | |
| MUSCULOSKELETAL | | | |
| 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.

Sport(s) _____ Today's Date _____ Gender: male female

Name: _____ Birthdate _____ Home Telephone _____

Grade (2009-2010): _____ School: HS 9th Grade Center Benold Tippit Forbes Student ID# _____

Current Address: _____
Street/P.O. Box _____ City _____ State _____ Zip _____

Father's name: _____ Daytime Phone: _____ Cell Phone: _____

Mother's name: _____ Daytime Phone: _____ Cell Phone: _____

Parent/Guardian's Email: _____

Health Insurance Company Name: _____ Member Name: _____

Member I.D. # _____ Group # _____ Policy # _____

If your insurance coverage requires (or if you prefer) a specific provider (clinic, doctor, HMO, etc.), please list the provider's name, address and phone number

Please indicate medical alerts such as allergies, contact lenses, asthma, etc. _____

IMPORTANT INSURANCE NOTICES

Catastrophic Health Insurance:
All students participating in athletics (including try-outs) in the Georgetown Independent School District (GISD) must purchase a catastrophic insurance policy arranged by the school district. Generally, this blanket policy pays benefits for medical expenses which exceed \$25,000.00 per occurrence (see plan documents for details). The cost for this insurance is \$10.00 for a student who participates in football and \$5.00 for a student who participates in any sport other than football.

Primary Health Insurance:
It is recommended that all students who are participating in athletics have personal health insurance or purchase the GISD voluntary health insurance plan. IF A STUDENT DOES NOT HAVE VALID PERSONAL INSURANCE COVERAGE, THE GISD VOLUNTARY POLICY IS HIGHLY RECOMMENDED. For additional information please contact the Athletic Training Department. The Catastrophic Insurance is different from the GISD Voluntary Policy.

RELEASES AND WAIVERS

Signify your approval by writing your initials in the space before the statement(s) and signing below:

- _____ 1. IN THE EVENT OF AN INJURY OR ILLNESS TO THE ABOVE-NAMED STUDENT, I HEREBY AUTHORIZE A REPRESENTATIVE OF GISD TO SECURE EMERGENCY MEDICAL TREATMENT FOR THE ABOVE-NAMED STUDENT FROM ANY HEALTHCARE PROVIDER.
- _____ 2. I UNDERSTAND THAT, IN ADDITION TO ANY PERSONAL HEALTH INSURANCE COVERAGE ON MY CHILD, I MUST PURCHASE CATASTROPHIC MEDICAL INSURANCE ARRANGED BY GISD. IN ADDITION, I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE, EITHER WITH PERSONAL HEALTH INSURANCE OR OTHER MEANS, FOR MEDICAL TREATMENT NEEDED BY MY CHILD. I AUTHORIZE GISD ATHLETIC TRAINER(S) TO FILE AN ELECTRONIC CLAIM FORM FOR THE CATASTROPHIC INSURANCE IF THE SITUATION ARISES.
- _____ 3. I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
- _____ 4. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS AND INFORMATION AS WELL AS MEDICAL INSURANCE INFORMATION TO THE GISD ATHLETIC TRAINER AND HEALTHCARE PROVIDERS AS NEEDED FOR TREATMENT OF INJURIES AND ILLNESS TO MY CHILD.
- _____ 5. I AUTHORIZE GISD ATHLETIC TRAINER (S) TO ADMINISTER NON-PRESCRIPTION MEDICATION TO MY CHILD.

Parent's/Guardian's Signature _____

Date _____

Athlete's Grade: _____

**NON-PRESCRIPTION MEDICATION
ACKNOWLEDGEMENT/ RELEASE FORM**

The following non-prescription medications can be made available for all athletes as deemed necessary by the athletic trainer following the guidelines and / or directions of a team physician:

Cough drops, antihistamine tablets, non-aspirin pain relief (acetaminophen, ibuprofen),

anti-acid tablets, decongestant tablets, anti-diarrhea tablets,

electrolyte replacement tablets, electrolyte drinks (Gatorade, Powerade),

anti-fungal crème, hydrocortizone crème, antibiotic ointment, hydrogen peroxide

My child may not have any of the above medications that I have circled.

Parent's/ Guardian's signature