STUDENT NAME LAST- _____FIRST-_____

ID#_____**GRADE (2019-20)**:_____

ACTIVITY(S):_____**SCHOOL:**_____

PREPARTICIPATION PHYSICAL EVALUATION-MEDICAL HISTORY

Please answer each question by circling "YES" or "NO". If you do not know the answer circle the question.

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 had prior testing for the heart ordered by a physician? YES NO
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 any 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

19. 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? _____

Males Only

20. Do you have two testicles?_____
21. Do you have any testicular swelling or masses?_____

***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)_____

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: _____

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 yes answers to specific questions on the students Medical History Form.

Height ____ Weight_____ %Body Fat____ Pulse_____ BP____/____
(____/____, ____/____)-brachial blood pressure while sitting
Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal OR Unequal

MEDICAL	NORMAL	ABNORMAL FINIDINGS	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			
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: _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue(question 3), 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. 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.

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**:_____