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.*

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 pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigma (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.

PREPARTICIPATION PHYSICAL EVALUATION----MEDICAL HISTORY

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 _________________ Cell ______________________ WK ___________________

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.

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 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 ___Yes ___No
   Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy) , hypertrophic cardiomyopathy,and long QT syndrome or other ion channelpathy (Brugana syndrome, etc). Marfan's syndrome or abnormal heart rhythum? ___Yes ___No
   Have you had a severe viral infection (for example, Myocarditis or mononucleosis) within the last month? ___Yes ___No ___Yes ___No
   Has a physician ever denied or restricted your participation in sports for any heart problems? ___Yes ___No ___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 (for example, 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 (for example, 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 sports? ___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? _____________

____

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 for and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

** EXPLAIN "YES" ANSWERS IN THE BOX BELOW (attach another sheet as needed)

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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 Sgnature:____Parent/Guardian Signature:____

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____________________________