PREPARTICIPATION PHYSICAL EVALUATION—PHYSICAL EXAMINATION

Student's Name: ____________________ Sex:__________ Age:________ Date of Birth:______________

School: ____________________ Grade:________ BP________/________(________/________,________/________)

Height:____________ Weight:____________ %Body fat (optional):____________ Pulse:____________

Vision R 20/ ________ L/20 ____________ Corrected: Y N Pupils: Equal ____________ Unequal ________

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. Examination forms signed by any other health care practitioner will not be accepted. The University Interscholastic League and HISD rules require this report to be completed and the exam to have been passed before a student participates in any tryouts, practices, games, or off-season programs.

When in the judgment of school staff members there appears to be a change in the physical status of an athlete after the physician's report is completed, the school may require another physical examination, and a release by the physician must then be obtained before an athlete will be allowed to continue in an activity.

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			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Previous surgery ____

Is student taking any medication routinely? ☐ Yes ☐ No (If yes, explain)______________________

Allergic to any medication?______________________________________

CLEARANCE

☐ Cleared: ____

☐ 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. 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 whether the student has developed any condition that would make it hazardous to participate in an athletic event.

Student's Name ______ 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 on an additional sheet. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 5, 7. 11, or 17 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.

	Question	Yes	No
1.	Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you had surgery in the past year?	☐	☐
3	Are you currently taking any prescription on non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or an abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times?______ When was the last concussion?______		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8.	Have you ever become ill from exercising in the heat?	☐	☐
9.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
10.	Have you had any problems with your eyes or vision?	☐	☐
11.	Are you missing any paired organs?	☐	☐
12.	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)?	☐	☐
13.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

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

	Question	Yes	No
14.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
15.	Do you feel stressed out?	☐	☐

16. Record the dates of your most recent immunizations (shots) for:

Tetanus ______ Measles ______

Hepatitis B ______ Chickenpox ______

	Question	Yes	No
17.	Are you under a doctor's care?	☐	☐

Females Only

18. 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: ______

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 Houston Independent School District 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 physician, 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.

To the parent:
Check any activity this student should be excluded from.

☐ Baseball	☐ Football	☐ Softball	☐ Tennis	☐ Wrestling
☐ Basketball	☐ Golf	☐ Swimming and Diving	☐ Track and Field	
☐ Cross-Country	☐ Soccer	☐ Team Tennis	☐ Volleyball	

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature ______ Parent/Guardian Signature ______ Date ______