

PAID:



PASADENA ISD-UIL ATHLETIC PARTICIPATION FORM GRADES 7-12

2019-2020

RECEIPT#

It is preferred that this original LT. BLUE form be used with the correct school year. NO PHYSICAL WILL BE PERFORMED OR ACCEPTED BEFORE THE FIRST PISD MASS PHYSICAL DATE. It is the athlete's responsibility to update new information as soon as it becomes available. (New address, phone number, etc...)

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER BEFORE A STUDENT ATHLETE CAN PARTICIPATE IN ANY ATHLETIC ACTIVITY WHICH INCLUDES TRY-OUTS, OFFSEASON, PRACTICE AND COMPETITION. ALL HIGH SCHOOL FORMS SHOULD BE GIVEN TO AN ATHLETIC TRAINER ONLY. INTERMEDIATE ATHLETIC FORMS SHOULD BE TURNED INTO YOUR CAMPUS COORDINATOR.

Please note you will need to have electronically signed all other documentation required by UIL which can be found at www.ranknesport.com before a student athlete can participate in ANY ATHLETIC ACTIVITY which includes TRY-OUTS, OFFSEASON, PRACTICE AND COMPETITION.

Student ID #: _____ Gender: Male / Female Date of Birth: ____/____/____ Age: _____ Grade (2019-2020): _____
Last Name: _____ First Name: _____ Home Phone: _____ Cell Number: _____
Address: _____ City/Zip: _____

Circle school attending in 2019-2020: Dobie PMHS Rayburn Pasadena South Houston

BHI Bondy Jackson Miller Park View Queens San Jacinto Southmore South Houston Thompson

Please circle one: Athletics/Fine Arts/Both

Pasadena ISD requires an annual physical exam and is good for 2019-2020 academic year only

Height: _____ Weight: _____ Pulse: _____ BP: _____
Vision: R - 20/ _____ L - 20/ _____ Pupils: Equal/Unequal Corrected: Y N

MEDICAL EXAMINER SECTION

Table with columns: MEDICAL, NORMAL, ABNORMAL FINDINGS, INITIALS*, CLEARANCE. Rows include: Appearance, Eyes/Ears, Nose/Throat, Lymph Nodes, Heart - Auscultation Supine, Heart - Auscultation Standing, Heart - Lower Extremity Pulses, 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). Includes checkboxes for 'Cleared' and 'Not cleared', and a 'Must Include Physician stamp to be valid' box.

* Station-based examination only

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 _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No 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"/> Yes <input type="checkbox"/> No Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____ When was your last concussion? _____ How severe was each one? (Explain below) _____ Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13.</p> <p>14.</p> <p>15.</p> <p>16.</p> <p>17.</p> <p>18.</p>	<p>Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below:</p> <table border="0" style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>Do you want to weight more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever been diagnosed with or treated for sickle cell trait or cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females only</i></p> <p>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? _____</p>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip																		
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh																		
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee																		
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf																		
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle																		
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot																			

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. I also authorize any physician to release confidential information concerning an athletic injury to the athletic trainer involved.

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. Your signature gives authorization which is necessary for the district, its trainer, coaches, and student insurance personnel to share information concerning medical diagnosis and treatment. This is to conform with Federal guidelines, ie. HIPAA and FERPA

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 _____