

STUDENT NAME (LAST, FIRST) \_\_\_\_\_

**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 channelopathy (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: \_\_\_\_\_

ID# \_\_\_\_\_ GRADE(2017-18): \_\_\_\_\_ School: \_\_\_\_\_

SPORT(S): \_\_\_\_\_ DOB: \_\_\_\_\_

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. The RRISD requires annual completion of this form.

Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_)-brachial blood pressure while sitting
Vision R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: Y N Pupils: Equal OR Unequal

Table with 4 columns: MEDICAL, NORMAL, ABNORMAL FINDINGS, INITIALS. Rows include: 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: \_\_\_\_\_

# Athlete Contact Information

|  |                           |                          |                   |
|--|---------------------------|--------------------------|-------------------|
| Last Name                                    | First Name                | Middle                   | Student ID #      |
| Date of Birth                                | Gender                    | School                   | 2017-2018 Grade   |
| Home Telephone Number                        | Student Cell Phone Number |                          |                   |
| Street Address (No P.O. Boxes)               | City                      | Zip Code                 |                   |
| Male Parent/Guardian's Name                  | Employer                  | Bus. Phone Number        | Cell Phone Number |
| Female Parent/Guardian's Name                | Employer                  | Bus. Phone Number        | Cell Phone Number |
| Emergency Contact Name ( <b>Non-Parent</b> ) | Home/Cell Phone Number    | Alternate Contact Number |                   |

## Online Form Instructions

Parent/Guardian:

You will need to navigate to <https://roundrockisd.rankonesport.com> to read, complete, and sign the following forms before your child is able to participate in athletics. ALL forms must be signed by a parent/guardian and the student athlete.

- RRISD Parent Consent Form
  - UIL Steroid Form
  - UIL Acknowledge of Rules
  - UIL Cardiac Awareness Form
  - UIL Concussion Form
  - RRISD ExCC Form
  - RRISD I & CS Form
- You must also complete the Pre-participation Medical History form(left side) on the back side of this sheet and then take the form to your doctor to have the Pre-participation Physical Exam(right side) completed by your doctor.
- Once the back side is completed please have your student turn it in to the Athletic Trainers for the high school or coach at their middle school.
- **Once you have completed the online forms, medical history, physical exam, athlete contact information portion of this form and turned it in to the Athletic Trainers/Middle School Coach, then your child will be eligible to participate in athletics (this includes practices during, before, after school, and offseason).**