

HEIGHTS SUMMER VOLLEYBALL SCHEDULE

2025

| | | | |
|------------|----------------------|------------------|----------------------|
| July 14-17 | Open Gym Mon.-Thurs. | July 28-August 1 | Two-a-days Mon.-Fri. |
| July 21-24 | Skill Camp | August 4 | Tryouts |

Open Gym: Open Gym will begin July 14th and conclude July 17th. Open Gym will be Monday through Thurs. 9:00 – 12:00. This is an invaluable opportunity to practice and refine your skills before tryouts.

Skill Camp: Skill Camp will begin on July 21 and conclude on July 24. Camp will be held from 9-1. This will provide an opportunity to refine skills before try-outs.

Two-A-Days: Are essentially two practices in one day. The first part of practice is from 8 to 11. There is a lunch break from 11 to 1. The second part of practice is from 1 to 3. **Both sessions are mandatory.**

Tryouts: Tryouts will be on August 4th. You must have a current physical dated after May 15th 2025 and it must be on the **HISD physical form**, which can be found on the HISD athletics website. You have the option to pay \$35.00 for HISD athletics insurance through School Pay on Heights High School Website or an insurance waiver which can be found on the HISD athletics website. **You may not try out without these 2 items.**

Paperwork: All paperwork should be filled out and the corresponding documents uploaded to Register My Athlete (RMA). All documents including: the medical history, physical, receipt from paying for HISD Insurance online or the Insurance Waiver form including the front and back of the insurance card. **All Paperwork must be uploaded to RMA by July 28, 2025.**

www.registermyathlete.com is the website to set up your account and upload all paperwork.

If you make a team:

- **You will receive a copy of our volleyball schedule.**
- **You are required to report for all practices and preseason games.**

If you have any questions over the summer contact Coach Lewis at clewis12@houstonisd.org or Coach Ehmling at gehmling@houstonisd.org

H EIGHTS VOLLEYBALL CAMP



When: July 21st -July 24th, 2025 (9 am-1 pm)

Where: Heights High School, 413 E. 13th Street, Houston, TX. 77008

For Who: Middle and High School Athletes

Price: \$100 Entire Camp Fee/\$35 Drop-In Fee

Payment Method: Cash

Contact: Coach Lewis (281)217-4547

Clewis12@houstonisd.org

If you have any questions please do not hesitate to call or e-mail

Please Bring Meds (i.e. Asthma Pump)

Player Name: _____ Age: _____

Parent Name: _____

E-mail: _____ Phone: _____

The undersigned being the parent/legal guardian of the player named above, hereby agrees to hold H.I.S.D., Heights High School, Chelsea Lewis, Gennifer Ehmling, Nevin Johnson, and Monica Peacock, the officers and directors, employees and coaches faultless in the event of injury or other harm occurring to the player during participation in all events. Parent/Guardian assures the player has adequate medical insurance and if necessary, will be responsible for any medical expenses.

Parent Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2024

This MEDICAL HISTORY FORM must be completed *annually* by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an 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.

| | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or physical? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below: | | |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh | | |
| Has any family member or relative died of heart problems or of sudden unexplained death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee | | |
| 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"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf | | |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle | | |
| Has a physician ever denied or restricted your participation in activities for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot | | |
| 4. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____ | | | 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| When was your last concussion? _____ | | | | | |
| How severe was each one? (Explain below) | | | | | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | Females Only <input type="checkbox"/> I choose not to provide written information on Question 19 but will discuss with a medical professional: | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. When was your first menstrual period? _____ | | |
| Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| 5. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 6. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____ | | |
| 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | Males Only <input type="checkbox"/> I choose not to provide written information on Question 20 but will discuss with a medical professional: | | |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Are you missing a testicle? _____ | | |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any testicular swelling or masses? _____ | | |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG. | | |
| 11. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | EXPLAIN "YES" ANSWERS IN THE BOX BELOW (attach another sheet if necessary): | | |

It is understood that even though protective equipment is worn by athletes, 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 participation, 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 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, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION 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 participation and again prior to first and third years of high school 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.*

| | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|--|--------|-------------------|-----------|
| MEDICAL | | | |
| 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) if indicated | | | |
| Skin | | | |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) | | | |

| | | | |
|---------------|--|--|--|
| 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 performance/games/matches.