

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

3024

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.

1. Have you had a medical illness or injury since your last check up or physical?

Yes

No

2. Have you been hospitalized overnight in the past year?

Yes

No

3. Have you ever had prior testing for the heart ordered by a physician?

Yes

No

4. Have you ever passed out during or after exercise?

Yes

No

5. Have you ever had chest pain during or after exercise?

Yes

No

6. Do you get tired more quickly than your friends do during exercise?

Yes

No

7. Have you ever had racing of your heart or skipped heartbeats?

Yes

No

8. Have you had high blood pressure or high cholesterol?

Yes

No

9. Have you ever been told you have a heart murmur?

Yes

No

10. Has any family member or relative died of heart problems or of sudden unexplained death before age 50?

Yes

No

11. 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

12. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?

Yes

No

13. Have you ever denied or restricted your participation in activities for any heart problems?

Yes

No

14. Have you ever had a head injury or concussion?

Yes

No

15. Have you ever been knocked out, become unconscious, or lost your memory?

Yes

No

16. If yes, how many times? _____

Yes

No

17. When was your last concussion? _____

Yes

No

18. How severe was each one? (Explain below)

Yes

No

19. Have you ever had a seizure?

Yes

No

20. Do you have frequent or severe headaches?

Yes

No

21. Have you ever had numbness or tingling in your arms, hands, legs or feet?

Yes

No

22. Have you ever had a stinger, burner, or pinched nerve?

Yes

No

23. Are you missing any paired organs?

Yes

No

24. Are you under a doctor's care?

Yes

No

25. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?

Yes

No

26. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?

Yes

No

27. Have you ever been dizzy during or after exercise?

Yes

No

28. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?

Yes

No

29. Have you ever become ill from exercising in the heat?

Yes

No

30. 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

14. Do you have asthma?

Yes

No

15. Do you have seasonal allergies that require medical treatment?

Yes

No

16. 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)?

Yes

No

17. Have you ever had a sprain, strain, or swelling after injury?

Yes

No

18. Have you broken or fractured any bones or dislocated any joints?

Yes

No

19. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?

Yes

No

20. If yes, check appropriate box and explain below:

Yes

No

21. Head

Yes

No

22. Neck

Yes

No

23. Back

Yes

No

24. Chest

Yes

No

25. Shoulder

Yes

No

26. Upper Arm

Yes

No

27. Elbow

Yes

No

28. Forearm

Yes

No

29. Wrist

Yes

No

30. Hand

Yes

No

31. Finger

Yes

No

32. Foot

Yes

No

33. Hip

Yes

No

34. Thigh

Yes

No

35. Knee

Yes

No

36. Shin/Calf

Yes

No

37. Ankle

Yes

No

38. Do you want to weigh more or less than you do now?

Yes

No

39. Do you feel stressed out?

Yes

No

40. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?

Yes

No

41. Females Only

Yes

No

42. I choose not to provide written information on Question 19 but will discuss with a medical professional:

Yes

No

43. 19. When was your first menstrual period? _____

Yes

No

44. When was your most recent menstrual period? _____

Yes

No

45. How much time do you usually have from the start of one period to the start of another? _____

Yes

No

46. How many periods have you had in the last year? _____

Yes

No

47. What was the longest time between periods in the last year? _____

Yes

No

48. Males Only

Yes

No

49. I choose not to provide written information on Question 20 but will discuss with a medical professional:

Yes

No

50. 20. Are you missing a testicle? _____

Yes

No

51. Do you have any testicular swelling or masses? _____

Yes

No

52. 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 and understand it is the responsibility of my family to schedule and pay for such ECG.

Yes

No

53. EXPLAIN "YES" ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

Yes

No

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.

54. 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.

55. 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.

56. 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.

57. Student Signature: _____

58. Parent/Guardian Signature: _____

59. Date: _____

60. 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.

61. For School Use Only:

62. This Medical History Form was reviewed by: Printed Name _____

63. Date _____

64. Signature _____

FRONT

COMPLETE PERSONAL, DOCTOR, AND EMERGENCY CONTACT INFO

COMPLETE ALL CHECK BOXES
EXPLAIN ANY YES ANSWERS IN THIS BOX

TOP LINE ONLY

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.

COMPLETE STUDENT & PARENT SIGNATURES, DATE

BACK

CHECK FOR DR SIGNATURE, ADDRESS, PHONE
NUMBER, DATE AND ID NUMBER
SHOULD HAVE STAMP

GRADE FOR 24-25 SY

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) JESSICA SANCHEZ Sex F Age 15 Date of Birth 09/18/08
Address 1234 LOBO WAY, HOUSTON, TX 77017 Phone 713-332-8501
Grade 10 School CHAVEZ HIGH SCHOOL
Personal Physician DR. MEREDITH GRAY Phone 832-432-4433
In case of emergency, contact:
Name MELISSA SANCHEZ Relationship MOTHER Phone (H) 713-332-8501 (W) 713-455-4646

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?	☐	☒	13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☒
2. Have you been hospitalized overnight in the past year?	☐	☒	Do you have asthma?	☐	☒
Have you ever had surgery?	☒	☐	Do you have seasonal allergies that require medical treatment?	☐	☒
3. Have you ever had prior testing for the heart ordered by a physician?	☐	☒	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)?	☐	☒
Have you ever passed out during or after exercise?	☐	☒	15. Have you ever had a sprain, strain, or swelling after injury?	☐	☒
Have you ever had chest pain during or after exercise?	☐	☒	Have you broken or fractured any bones or dislocated any joints?	☐	☒
Do you get tired more quickly than your friends do during exercise?	☐	☒	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☒
Have you ever had racing of your heart or skipped heartbeats?	☐	☒	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	☐	☒	☐ Head	☐ Elbow	☐ Hip
Have you ever been told you have a heart murmur?	☐	☒	☐ Neck	☐ Forearm	☐ Thigh
Has any family member or relative died of heart problems or of sudden unexplained death before age 50?	☐	☒	☐ Back	☐ Wrist	☐ 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?	☐	☒	☐ Chest	☐ Hand	☐ Shin/Calf
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☒	☐ Shoulder	☐ Finger	☐ Ankle
Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☒	☐ Upper Arm	☐ Foot	
4. Have you ever had a head injury or concussion?	☐	☒	16. Do you want to weigh more or less than you do now?	☐	☒
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☒	17. Do you feel stressed out?	☐	☒
If yes, how many times?			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☒
When was your last concussion?			Females Only ☐ I choose not to provide written information on Question 19 but will discuss with a medical professional:		
How severe was each one? (Explain below)			19. When was your first menstrual period? 11		
Have you ever had a seizure?	☐	☒	When was your most recent menstrual period? MAY 22		
Do you have frequent or severe headaches?	☐	☒	How much time do you usually have from the start of one period to the start of another? 28 DAYS		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☒	How many periods have you had in the last year? 12		
Have you ever had a stinger, burner, or pinched nerve?	☐	☒	What was the longest time between periods in the last year? 29 DAYS		
5. Are you missing any paired organs?	☐	☒	Males Only ☐ I choose not to provide written information on Question 20 but will discuss with a medical professional:		
6. Are you under a doctor's care?	☐	☒	20. Are you missing a testicle?		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☒	☐	Do you have any testicular swelling or masses?		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☒	☐	☐ 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.		
9. Have you ever been dizzy during or after exercise?	☐	☒	EXPLAIN "YES" ANSWERS IN THE BOX BELOW (attach another sheet if necessary):		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☒			
11. Have you ever become ill from exercising in the heat?	☐	☒			
12. Have you had any problems with your eyes or vision?	☒	☐			

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: Jessica Sanchez Parent/Guardian Signature: Melissa Sanchez Date: 06-21-2024

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 NameJESSICA SANCHEZSexFAge15Date of Birth09/18/08

Height5'8Weight185% Body fat (optional)Pulse70BP144/66brachial blood pressure while sitting

Vision: R 20/20L 20/20Corrected:YNPupils:EqualUnequal

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	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 (arachnodaetyly, 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)Grey - Sloane Memorial HospitalDate of Examination:6/21/24

Address:2626 Loop west #202

Phone Number:houston, tx, 77054

Signature:713-661-7246Meredith Grey10429

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.