

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?	☐	☐	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? _____					
How severe was each one? (Explain below)					
Have you ever had a seizure?	☐	☐	Females Only ☐ I choose not to provide written information on Question 19 but will discuss with a medical professional:		
Do you have frequent or severe headaches?	☐	☐	19. When was your first menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐	When was your most recent menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	☐	☐	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?	☐	☐	How many periods have you had in the last year? _____		
6. Are you under a doctor's care?	☐	☐	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?	☐	☐	Males Only ☐ 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)?	☐	☐	20. Are you missing a testicle? _____		
9. Have you ever been dizzy during or after exercise?	☐	☐	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)?	☐	☐	☐ 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?	☐	☐			
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: _____

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.

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: _____