

22-23 V.M.F.

PREPARTICIPATION PHYSICAL EVALUATION - PHYSICAL EXAMINATION

Stu ID _____

Students Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ (/ /)
 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.

INITIALS* NORMAL ABNORMAL FINDINGS INITIALS*

MEDICAL	ABNORMAL FINDINGS	INITIALS*
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		
Martian'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.

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 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 _____

Grade _____ School _____

Personal Physician _____ Phone _____

Name _____ Relationship _____ Phone (H) _____ (W) _____

In case of emergency, contact: _____

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?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2.	Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3.	Have you ever had surgery?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	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 sudden unexplained 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 activities for any heart problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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
5.	Are you missing any paired organs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6.	Are you under a doctor's care?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9.	Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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
11.	Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
12.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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? _____

20. Are you missing a testicle? _____

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

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.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

Males Only

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

17. Do you feel stressed out?

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

<input type="checkbox"/>	Head	<input type="checkbox"/>	Upper Arm	<input type="checkbox"/>	Foot
<input type="checkbox"/>	Neck	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Finger
<input type="checkbox"/>	Forearm	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Hand
<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Back	<input type="checkbox"/>	Wrist
<input type="checkbox"/>	Hip	<input type="checkbox"/>	Thigh	<input type="checkbox"/>	Knee
<input type="checkbox"/>		<input type="checkbox"/>	Shin/Calf	<input type="checkbox"/>	Ankle

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: _____ Date: _____

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, PERFORMANCE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only

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