X STUDENT ID#

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 12-4-14

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

NAME (print)	Grade	Sex	Date of Birth
ALLERGIES			
REGULAR MEDICATIONS:			
MEDICAL CONDITIONS			

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
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?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	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 weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

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? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), 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.

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

_____

_____

_____

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.

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

X ***PARENT/GUARDIAN SIGN*** _____ ***DATE*** _____ X ***STUDENT SIGN*** _____

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 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 ID# _____

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 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 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)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
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 games/matches.

SUDDEN CARDIAC ARREST AWARENESS FORM / CONCUSSION ACKNOWLEDGEMENT FORM

Revised February 2014

Name of Student: _____

Parent/Guardian signature _____

Student Signature _____

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short---circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability ofthe heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What causes Sudden Cardiac Arrest?

Conditions present at birth

Inherited (passed on from parents/relatives) conditions of the heart muscle:

-Hypertrophic Cardiomyopathy – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.

-Arrhythmogenic Right Ventricular Cardiomyopathy – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy. *-Marfan Syndrome – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.*

Inherited conditions of the electrical system:

- Long QT Syndrome – abnormality in the ion channels (electrical system) of the heart.
- Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome -other types of electrical abnormalities that are rare but are inherited.

NonInherited (not passed on from the family, but still present at birth) conditions:

- Coronary Artery Abnormalities – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
- Aortic valve abnormalities – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
- Non---compaction Cardiomyopathy – a condition where the heart muscle does not develop normally.
- Wolff---Parkinson---White Syndrome –an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.

Conditions not present at birth but acquired later in life:

- Commotio Cordis – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
- Myocarditis – infection/inflammation of the heart, usually caused by a virus.
- Recreational/Performance Enhancing drug use.

Idiopathic: Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

What are the symptoms/warning signs of Sudden Cardiac Arrest?! Fainting/blackouts (especially during exercise)

Dizziness Nausea/ vomiting | Unusual fatigue/weakness | Chest pain | Shortness of breath

Palpitations (heart is beating unusually fast or skipping beats) | Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your MD before returning to practice or a game.

What is the treatment for Sudden Cardiac Arrest?Time is critical and an immediate response is vital

CALL 911 | Begin CPR | Use an Automated External Defibrillator (AED)

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre---participation history and physical including 12 important cardiac elements.
- The UIL Pre---Participation Physical Evaluation – Medical History form includes ALL 12 ofthese important cardiac elements and is mandatory annually.

-Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find information on additional screening?

- Check the Health & Safety page of the UIL website (http://www.uiltexas.org/health) or do an internet search for "Sudden Cardiac Arrest"

CONCUSSION ACKNOWLEDGEMENT FORM

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.Follow the rules of play.Make sure the required protective equipment is worn for all practices and gamesProtective equipment must fit properly and be inspected on a regular basis..

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vi-sion, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsy-chologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence

Treatment of Concussion - The student-athlete shall be removed from practice or competition immediately if suspected to have sus-tained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is rest. Also avoid external stimulation such as watching television, music, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written Return to Play - According to the Texas Education Code, Section 38.157:clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:

(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physi-cian chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;

(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;

(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and

(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;

(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and

(C) have signed a consent form indicating that the person signing:

(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;

(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;

(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommenda-tions of the treating physician; and(iv) understands the immunity provisions under Section 38.159.

PFLUGERVILLE ISD EMERGENCY STUDENT INFORMATION PAGE

PARTICIPATION, MEDICAL HISTORY (newest version from UIL website) AND PHYSICAL (newest version from UIL website) FORMS MUST BE COMPLETED ANNUALLY AND ON FILE WITH THE ATHLETIC TRAINERS BEFORE THE ATHLETE COMPETES IN ANY PRACTICE (BEFORE OR AFTER THE SEASON) OR GAMES/MATCHES. Use only BLACK or BLUE ink – NO PENCIL.
Please PRINT ALL INFORMATION

Name _____ School ID#_____

Date of Birth _____/_____/_____ Age (today) _____ Student cell # _____ Grade (Today)_____

Address _____ City/Zip _____

Fathers Name _____ Phone _____ Cell _____

Mothers Name _____ Phone _____ Cell _____

Contact Email _____

Person to reach if parents cannot be notified _____ Phone _____

SPECIAL CONSIDERATION THAT SHOULD BE KNOWN BY ATHLETIC TRAINING STAFF MEMBERS

ALLERGIES / MEDICAL CONCERNS _____ MEDICATIONS TAKEN REGULARLY _____

ASTHMA yes no OTHER CONCERNS / WARNINGS _____

NON-PRESCRIPTION MEDICATION PERMIT

This medication permit form is required for compliance of the Texas Education Agency School Health Act and PISD Board Policy.
I hereby give my consent to the PISD staff and Physicians to administer the non-prescription items to my child as checked below.

____ Acetaminophen (Tylenol) ____Antacids (Tums) ____ Ibuprofen (Advil)

PISD CONCUSSION MANAGEMENT PLAN

When a student is diagnosed with a concussion the Pflugerville ISD athletic training staff and coaches will work with the athlete, parents, and teachers to ensure appropriate accommodations according to physician's recommendations.
In the event a student athlete is suspected of a concussion the following steps will be executed:

1. Establish immediate communication with the parents and coaches involved
2. Remove the student from athletic participation (No athlete can return to play the same day of the injury)
3. Evaluated by a Pflugerville ISD Licensed Athletic Trainer under the direction of a Licensed Physician
4. Follow the graduated protocol to return to play as directed by the physician
5. Will not return to play until we have written authorization from the Physician and Athletic Trainer

GRADUATED RETURN TO PLAY PROTOCOL The return to play protocol is designed to ensure that the athlete is fully healed before returning to play. This is a step process that progresses from complete rest to full exertion under the supervision of a Pflugerville ISD Licensed Athletic Trainer under the direction of a Licensed Physician. The athlete must become asymptomatic from rest to full exertion. Each step must be achieved before moving to the next. If at any point the symptoms reoccur the will return to the previous step.
The key to the management of a concussion is physical and cognitive rest until the symptoms resolve and then a graduated program to return to play under the supervision of a medical professional. As stated above it is extremely important that the athlete not only receive physical rest but cognitive rest. To achieve cognitive rest one must reduce or eliminate stimulus such as scholastic work, texting, video games, television, etc.

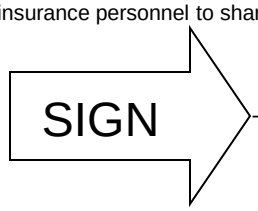
Parent or Guardians Permit

I hereby give consent for the above named student to compete in UIL/PISD approved athletic sports and travel with the coach or other school representative on any trips. I also agree to be responsible for the safe return of all athletic equipment issued by the school to the above names student and will pay for any and all lost, stolen, or damaged equipment.

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.

Your signature below gives authorization that is necessary for the school district, its athletic trainers, coaches, associated physicians, and student insurance personnel to share information concerning medical diagnosis and treatment for your student.



_____ _____

Parent/Guardian Signature Date

ALL 4 PAGES MUST BE FILLED OUT