EANES ISD PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY FORM

This **FORM** must be **COMPLETED IN FULL** 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:	DOB:
Address:			Phone:
Grade:	School:		**Student ID:**
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
1	Have you had a medical illness or injury since your last check up or 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 every 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 activities for any heart problems?		
4	Have you ever had a head injury or concussion?		
	Have you ever been knocked out, become unconcsious, 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 activity 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, circle the appropriate body parts 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 sickle 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? _____

MALES ONLY

20 Do you have two testicles? _____
21 Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about 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)

It is understoof 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 judgement 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 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 review by: Printed Name: _____ Date: _____ Signature: _____

EANES ISD 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

EANES ISD POLICY REQUIRES EACH ATHLETE HAVE AN ANNUAL PHYSICAL DATED AFTER MAY 1, 2024

	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 performance/ games/matches.