

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

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.

<p>1. Have you had a medical illness or injury since your last check up or physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. 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 of sudden unexpected 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</p> <p>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</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below:</p> <table border="0" style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females Only</i></p> <p>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? _____</p> <p><i>Males Only</i></p> <p>20. Do you have two testicles? _____</p> <p>21. Do you have any testicular swelling or masses? _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> 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.</p> <p>EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</p> </div>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
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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.**

For School Use Only:

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

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)			
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.



HEALTH HISTORY AND CONSENT FORM

Insurance: _____

NAME: (Last, First, Middle) _____ Birth Date: _____

Primary Care Doctor: _____ Specialist Doctor: _____

Reason for visit today? _____

DO YOU:

1. Do you smoke? _____ If yes, how much? _____ How many years? _____ If quit, when? _____
2. Do you drink alcohol? _____ If yes, how much? _____ If quit, when? _____
3. Do you use any recreational/street drugs? If yes, what kind? _____
4. Any recent travel? If yes where? _____
5. Occupation: Current _____ Past Occupations (if applicable) _____
6. [Females ONLY] Last Menstrual Period _____ Hysterectomy _____ Menopause _____
7. [Pediatrics ONLY] Are childhood vaccines up to date? (circle one) Yes or No

List ALL Medications you take or are supposed to take and what they are for (Including vitamins and Birth Control): _____

Immunizations **Month/Year**
 Tetanus (TD): _____
 Pneumonia: _____
 Flu: _____

List ALL Drug Allergies: _____

Previous Surgeries and Hospitalizations: _____

Current and Past Illnesses: (check each item Yes or No; If yes, write "C" if the problem still exists)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Arthritis/Pain			High B.P			Kidney Disease			Aortic Disease		
Anemia			Heart disease			Kidney Stones			Migraines		
Bleeding disorder			Stroke/TIA			Diabetes			Pneumonia		
Allergies/Hay fever			Epilepsy/Seizure			Thyroid Disease			Anxiety		
Asthma			Liver Disease			Depression			Reflux/Ulcer		
Emphysema/COPD			High Cholesterol			DVT/PE			Cancer of		

Other Illnesses or Injuries not listed above: _____

FAMILY HISTORY: Among your MOTHER/FATHER/SISTER/BROTHER, does anyone have/had the following? (check appropriate boxes)

Family History of:	Yes	No	If yes, who has/had it?	Family History of:	Yes	No	If yes, who has/had it?
Asthma				Aortic Disease			
Diabetes				Sudden Cardiac Death			
High Blood Pressure				High Cholesterol			
Heart Attack				Breast Cancer			
Heart Disease (other)				Colon Cancer			
Stroke/TIA				Other Cancers			
Seizures/Epilepsy				Other			

CONSENT: I hereby authorize Texpress Urgent Care & its provider(s) to perform the necessary exams/procedures for the health assessment and treatment of myself and/or my children, and to furnish the resulting health information to appropriate parties.

Signature: _____ Relationship to Patient: _____ Date: ____/____/____