# JUDSON ISD PREPARTICIPATION PHYSICAL EVALUATION

*THIS FORM MAY ONLY BE RETURNED TO A **STAFF ATHLETIC TRAINER** IN PERSON WHEN COMPLETE.*

**Student's Name: (print)**_______________________________ **Student ID #:**______________ **Grade ('20-'21):**________

**Sex:** ( MALE / FEMALE ) **School:**______________ **Date of Birth:**______________ **Age:**______ **Phone #:**______________

**Street Address:**_______________________________ **City:**______________ **State:**_____ **Zip Code:**____________

**Personal Physician:**_______________________________ **Phone #:**______________

*In case of emergency, contact:*

**Name:**______________________ **Relationship:**______________ **Phone (H):**____________ **Phone (W):**____________

## 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 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.

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 sports physical? YES NO
2. Have you been hospitalized overnight in the past year? YES NO
   Have you ever had surgery? YES NO
3. Have you ever had prior testing for the heart ordered by a physician? YES NO
   Have you ever passed out during or after exercise? YES NO
   Have you ever had chest pain during or after exercise? YES NO
   Do you get tired more quickly than your friends do during exercise? YES NO
   Have you ever had racing of your heart or skipped heartbeats? YES NO
   Have you had high blood pressure or high cholesterol? YES NO
   Have you ever been told you have a heart murmur? YES NO
   Has any family member or relative died of heart problems or of sudden unexpected death before age 50? YES NO
   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? YES NO
   Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO
   Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO
4. Have you ever had a head injury or **concussion**? YES NO
   Have you ever been knocked out, become unconscious, or lost your memory? YES NO
   If yes, how many times? _______
   When was the last concussion?______________
   How severe was each one? (Explain Below)
   Have you ever had a **seizure**? YES NO
   Do you have frequent or severe headaches? YES NO
   Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO
   Have you ever had a stinger, burner, or pinched nerve? YES NO
5. Are you missing any paired organs? YES NO
6. Are you under a doctor's care? YES NO
7. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an **inhaler**? YES NO
8. Do you have any **allergies** (for example, to pollen, medicine, food, or stinging insects)? YES NO
9. Have you ever been dizzy during or after exercise? YES NO
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? YES NO
11. Have you ever become ill from exercising in the heat? YES NO
12. Have you had any problems with your eyes or vision? YES NO
13. Have you ever gotten unexpectedly short of breath with exercise? YES NO
    Do you have **asthma**? YES NO
    Do you have seasonal allergies that require medical treatment? YES NO
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)? YES NO
15. Have you ever had a sprain, strain, or swelling after injury? YES NO
    Have you broken or fractured any bones or dislocated any joints? YES NO
    Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO
    If yes, check appropriate box and explain below.
    □Head □Neck □Back □Chest
    □Shoulder □Upper Arm □Elbow □Forearm
    □Wrist □Hand □Finger □Foot
    □Hip □Thigh □Knee □Shin/Calf
    □Ankle
16. Do you want to weigh more or less than you do now? YES NO
17. Do you feel stressed out? YES NO
18. Have you ever been diagnosed with or treated for sickle cell trait or **sickle cell disease**? YES 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?__________

**Males Only**

20. Do you have two testicles?__________
21. Do you have any testicular swelling or masses?______________

☐ An electrogcardiogram (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):**

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 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 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 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 OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

***FOR SCHOOL USE ONLY:***

This medical history form was reviewed by: Printed Name: Signature: Date:

Student's Name ______________________ Sex ________ Age ________ Date of Birth ____________________

**PREPARTICIPATION PHYSICAL EVALUATION –PHYSICAL EXAMINATION**

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 students Medical History Form on the reverse side. **Local district policy may require an annual physical exam.*

Height_____Weight_____% Body Fat (optional)___Pulse____BP____/______

(_____/_____,_____/_____)-brachial blood pressure while sitting

Vision R 20/____ L 20/_______ Corrected: Y N Pupils: Equal OR Unequal

| | 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 (Please check one)**

☐ **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):**______________________

**Address:**____________________________

**Phone Number:**____________________________

**Physician Signature:**____________________________

**Date of Examination:**______________________

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.

# Rank One Sport

# Online Form Instructions

YOU MUST COMPLETE ALL ONLINE PAPERWORK <u>BEFORE</u> PARTICIPATING IN ANY ATHLETIC EVENT OR PRACTICE

***Forms require both parent and student signatures***

⇒ Click on **Electronic Participation Forms** at the top and then **Athletics Participation Form** in the drop down menu

⇒ Fill out — First Name, Last Name, ID Number exactly as it is listed with the registrar

⇒ Fill out — All information requested

- ⇒ Do not leave any blanks (Use N/A if needed)
- ⇒ Missing information is highlighted in **red**

⇒ Electronically sign the document

⇒ Enter your email address and submit

⇒ A **pre-participation Form** must also be on file prior to participation in athletics. This may only be turned into one of the **Staff Athletic Trainers**

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## Athletic Training Room Information

| School | Room # | Office # |
|---|---|---|
| Wagner High School | H118 | 210-662-5020 |
| Veterans Memorial High School | F126 | 210-619-0220 |
| Judson High School | M123 | 210-945-1108 |