



# PRE-PARTICIPATION PHYSICAL EVALUATION 2019-2020 SCHOOL YEAR

*To be completed by the Parent:*

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ SPORT(s): \_\_\_\_\_

FATHER/GUARDIAN NAME: \_\_\_\_\_ MOTHER/GUARDIAN NAME: \_\_\_\_\_

EMAIL: \_\_\_\_\_ EMAIL: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

FATHER'S EMPLOYER: \_\_\_\_\_ MOTHER'S EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACTS	
NAME: _____	NAME: _____
PHONE: _____	PHONE: _____
EMAIL: _____	EMAIL: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE PROVIDER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

MEDICINES: List all prescription, over the counter, and supplements student is currently taking: \_\_\_\_\_

**DIRECTIONS:** Complete questions below and explain "YES" answers in the space provided.

GENERAL QUESTIONS	YES	NO	UNSURE
1. Has your doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? If so check all that apply: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____			
3. Have you ever spent the night in the hospital in the past year?			
4. Have you ever had surgery?			
HEART HEALTH QUESTIONS	YES	NO	UNSURE
5. Have you ever passed out or nearly passed out during or after exercise?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection <input type="checkbox"/> Other: _____			
9. Do you get lightheaded or feel more short of breath than expected during exercise?			
10. Have you ever had an unexplained seizure?			
11. Do you get more tired or short of breath more quickly than your friends during exercise?			
FAMILY HEART HEALTH QUESTIONS	YES	NO	UNSURE
12. Has any family member or relative died of heart problems or unexpected sudden death before age 50?			

13.

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14. Has any family member been diagnosed with a heart condition?			
<b>BONE AND JOINT QUESTIONS</b>	<b>YES</b>	<b>NO</b>	<b>UNSURE</b>
15. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?			
16. Have you had any fractured bones or dislocated joints?			
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast?			
18. Do you regularly use a brace, orthotics or other assistive device?			
19. Do any of your joints become painful, swollen, feel warm or look red?			
<b>MEDICAL QUESTIONS</b>	<b>YES</b>	<b>NO</b>	<b>UNSURE</b>
20. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
21. Do you have any allergies? If so, check all that apply: <input type="checkbox"/> Pollen <input type="checkbox"/> Medicine <input type="checkbox"/> Food <input type="checkbox"/> Stinging Insects <input type="checkbox"/> Other: _____			
22. Are you missing any paired organs?			
23. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?			
24. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?			
25. Have you ever had a head injury or concussion?			
26. Have you ever been knocked unconscious or lost memory?			
27. Do you have a history of seizure disorder?			
28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
29. Have you ever become ill while exercising in the heat?			
30. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?			
31. Have you had any problems with your eyes or vision?			
32. Have you ever had unexpected shortness of breath with exercise?			
33. Have you had any eye injuries?			
34. Do you use any special protective or corrective equipment?			
35. Do you lose weight regularly to meet weight requirements for an extra-curricular activity?			
36. Are you on a special diet or do you avoid certain foods?			
37. Have you ever had an eating disorder?			
38. Are you presently under a doctor's care?			
39. Do you have any concerns you would like to discuss with a doctor?			
<b>FEMALES ONLY</b>			
40. What year was your first menstrual cycle?			
41. What month and day was your most recent menstrual cycle?			
42. How many cycles have you had in the last 12 months?			
<b>Explain "YES" answers:</b>			

**Parental Consent**

I grant permission for my child to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by my participating child. I agree on behalf of myself, my participating child, our heirs, successors and assigns, to hold harmless and defend the school, its employees, officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from our in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees or expenses arising in connection therewith. I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# PHYSICAL EXAMINATION FORM 2019-2020 SCHOOL YEAR

*To be completed by the Physician/Licensed Examiner*

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

<b>EXAMINATION</b>			
Height: _____	Weight: _____	Pulse: _____	Blood Pressure: _____ / _____
Vision R 20/ _____	L 20/ _____	Corrected: Yes _____ No _____	Pupils: Equal _____ Unequal _____
Hearing: Normal _____	Referred _____	Spinal Exam: Normal _____ Referred _____	% Body Fat (optional) _____

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart-Auscultation of the heart in the <b>supine</b> position		
Heart-Auscultation of the heart in the <b>standing</b> position		
Heart-lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

<b>MUSCULOSKELETAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

<b>CLEARANCE</b>	
<input type="checkbox"/> Cleared for all sports without restriction <input type="checkbox"/> Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____ <input type="checkbox"/> Not cleared	<input type="checkbox"/> Pending further evaluation <input type="checkbox"/> For any sport <input type="checkbox"/> For certain sports: Reason: _____
Recommendations: _____	

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

# CONCUSSION AND TRAUMATIC BRAIN INJURY

## What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way a student's brain normally functions
- Can occur during practice or contests in any sport
- Can occur in activities both associated and not associated with the school
- Can occur even if the student has not lost consciousness
- Can be serious even if a student has just been "dinged" or had their "bell rung"

## Are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, one or more of the following symptoms may become apparent. The student may not "feel right" soon after, a few days after or even weeks after the injury event.

Headache	"Pressure" in the head	Nausea	Vomiting
Balance problems	Dizziness	Blurry Vision	Double Vision
Sensitivity to Light	Sensitivity to Noise	Confusion	Memory Problems
Difficulty paying attention	Feeling sluggish, hazy, foggy or groggy		

If you have concerns regarding any of the above symptoms, your doctor should be consulted for further information and/or examination. Your physician or medical professional can best determine your student's physical condition and ability to participate in athletics.

## What should students do if they believe that they or someone else may have a concussion?

- Students should immediately notify their coach or school personnel.
- Student should be examined by appropriate medical personnel of the parent's choosing. The medical provider should be trained in the diagnosis and treatment of concussions
- If no concussion is diagnosed, the student shall be cleared to return to athletic participation.
- If a concussion is diagnosed, the school protocol for return to play from a concussion shall be enacted. Under no circumstances shall the student be allowed to return to practice or play without the approval of a licensed medical provider trained in the treatment of concussions.

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**I have reviewed the above material. I understand the symptoms and warning signs of CONCUSSIONS. Additional information is available on the Health and Safety page at [www.tapps.biz](http://www.tapps.biz). All concussions should be reported to the school as soon as possible. Previous concussions should be reported on the Medical History form to allow the medical practitioner the best information possible when conducting the annual physical examination.**

Parent Signature / Date: \_\_\_\_\_

Student Signature / Date: \_\_\_\_\_

**CONCUSSIONS – Don't hide it. Report it. Take time to recover.**

# SUDDEN CARDIAC ARREST

## What is Sudden Cardiac Arrest (SCA)?

Sudden Cardiac Arrest is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is not a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction of the heart's electrical system, causing the heart to stop beating.

## How common is Sudden Cardiac Arrest?

While studies differ in the actual rate of occurrence, the American Heart Association information indicates that there are approximately 300,000 SCA events outside hospitals each year in the United States. About 2000 patients under the age of 25 die of SCA each year. Studies now being performed in Texas and other states indicate the occurrence rate for high school age athletes may be greater than this figure.

## Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

Dizziness	Fatigue	Lightheadedness
Extreme tiredness	Shortness of breath	Nausea
Difficulty breathing	Vomiting	Racing or fluttering heartbeat
Chest Pains	Syncope (fainting)	

These symptoms can be confusing and unclear in athletes. Often people confuse these warning signs as physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

For this reason these symptoms are included on the Medical History form provided by TAPPS and required for each student prior to participation in athletic events each year. As parents and student athletes, your truthful answers to these simple questions will assist your medical practitioner when performing the annual physical examination.

## What are the risks of participation and playing with these symptoms?

Continued participation brings with it increased risk. This includes playing in practices and games. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just minutes. Most people who experience a SCA die from the event.

While TAPPS does not mandate Cardiac Screening prior to participation, TAPPS and the TAPPS member schools recognize the importance of our students' health and highly recommend discussing screening options with your healthcare provider. Any student who shows signs of SCA should be removed by the parents from play. This includes all athletic activity, practices or contests. Before returning to play, the student should be examined and receive clearance by a licensed health care professional of the parents' choosing.

**I have reviewed the above material. I understand the symptoms and warning signs of SCA.  
Additional information is available on the Health and Safety page at [www.tappp.biz](http://www.tappp.biz).**

Parent Signature / Date: \_\_\_\_\_

Student Signature / Date: \_\_\_\_\_

# PARENT AND STUDENT NOTIFICATION STEROID USE AGREEMENT FORM

State law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.

State law requires that only a medical doctor may prescribe a steroid for a person.

State law provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person in good health is not a valid medical purpose.

Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

## HEALTH CONSEQUENCES ASSOCIATED WITH ANABOLIC STEROIDS

(source: National Institute on Drug Abuse)  
<http://www.nida.nih.gov/Infofacts/steroids.html>

**For boys and men** – shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts, increased risk for prostate cancer.

**For girls and women** – growth of facial hair, male-pattern baldness, changes in or cessation of the menstrual cycle, enlargement of the clitoris, deepened voice.

**For adolescents** – growth halted prematurely through premature skeletal maturation and accelerated puberty changes. This means that adolescents risk remaining short for the remainder of their lives if they take anabolic steroids before the typical adolescent growth spurt.

**For all ages** – potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension which can promote heart attack and stroke; and acne. Available evidence may suggest that anabolic steroid abuse, particularly in high doses, promotes aggression that can manifest as fighting, physical and sexual abuse, and property crimes. Upon stopping anabolic steroids, some abusers may experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, headaches, muscle and joint pain and the strong desire to return to the use of anabolic steroids.

**For Injectors** – infections resulting from the use of shared needles or non-sterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

## STUDENT CERTIFICATION

I have read the above information and agree that I will not use illegal anabolic steroids.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

## PARENT / GUARDIAN CERTIFICATION

I have read the above information and agree to my knowledge my student will not use illegal anabolic steroids.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

