Commerce Athletic Training

To: Commerce ISD Student-Athletes and Parents

From: Amanda Herron MS, ATC, LAT
Head Athletic Trainer

Subject: Student-Athlete Pre-Season Forms

Attached are the instructions to complete the medical paperwork for participation in any athletic activities for the 2023-2024 athletic year. **ALL STUDENT-ATHLETES must complete the medical history and UIL forms prior to the start of your season to participate each year**. UIL forms will be completed electronically in a Google Form (Link & QR below). Please keep in mind that this form is confidential and is for your benefit.

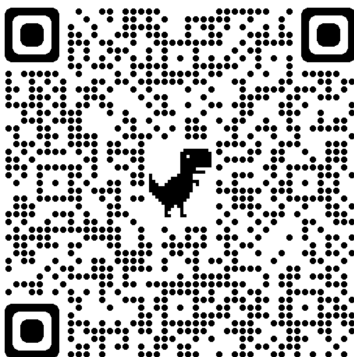
Physical Exam:
Needs to be completed by a Medical Doctor (***incoming 7th, 9th and 11th graders***). The physical form is attached. Physicals will be provided free of charge. All forms must be completed prior to receiving a physical exam. **Physical Date is SATURDAY April 29th,** students will be bussed to Sulphur Springs from Commerce HS and return once all students have finished. Physicals will be conducted by Christus Trinity Mother Frances Health System providers. If the Medical history and UIL forms are not **completed prior to 4/14/23** you will be responsible for getting your child a physical by May 26th.

ATHLETIC/UIL FORMS:
SCAN the QR code or TYPE the link into a web browser to complete the forms. **PARENTS** are responsible for completing the forms with their child. ***Please fill in information completely and correctly, this is for your Childs benefit, especially in case of an emergency.***

LINK TO GOOGLE FORM:
https://rb.gy/xe4thg

Return FORMS by **APRIL 14thth** to:
Amanda Herron at CHS.
Head Athletic Trainer
Office: 903.886.3756
Fax: 903.886.6209
Email: amanda.herron@commerceisd.org

SCAN QR TO COMPLETE REQUIRED FORMS



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 that would make it hazardous to participate in an athletic event.

Student's Name: (print) ____Gender ____________ Age____________ Date of Birth_______________

Address ____ Student's Phone: _________________________

Grade (23-24)_____________________ School ____________________________________ Sports ____

Personal Physician: ____ Phone: ____

In case of emergency, contact:
Name: ___________________________________ Relationship___________________ Phone (C): ______________________ (Alternate)______________

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?	☐	☐
	Have you ever had your heart race 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?	☐	☐
	Had any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc) Marfan's Syndrome, or abnormal heart rhythm?	☐	☐
	Have you ever had a severe viral infection (ie. 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 in "Yes" box)		
	Do you have frequent 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.	Do you have diabetes? Or require insulin?	☐	☐
6.	Have you ever had a seizure?	☐	☐
7.	Are you missing any paired organs?	☐	☐
8.	Are you under a doctor's care?	☐	☐
9.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
10.	Do you have any allergies (ie. To pollen, medicine, food, or insect stings)?	☐	☐
11.	Have you ever been dizzy during or after exercise?	☐	☐
12.	Do you have any current skin problems (ie. Itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
13.	Have you ever become ill from exercising in the heat?	☐	☐
14.	Have you had any problems with your eyes or vision?	☐	☐
15.	Do you have ADD/ADHD/Learning Disability?	☐	☐

		Yes	No
16.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have any seasonal allergies that require medical treatment?	☐	☐
17.	Do you use any special protective for corrective equipment or devices that aren't usually used for sports for position (ie. Knee brace, neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
18.	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 the appropriate box and explained below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	☐ Toe

		Yes	No
19.	Do you want to weigh more or less than you do?	☐	☐
20.	Do you feel stressed out?	☐	☐
21.	Have you ever been tested for sickle cell disease or trait?	☐	☐
22.	Have you ever been diagnosed with or treated for sickle cell trait or disease?	☐	☐
23.	Do any family members carry or have sickle cell anemia?	☐	☐

Females Only

24. 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? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question 3 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, 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 is the UIL nor the school assumes any responsibility.

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 might 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. I acknowledge and agree that all information on UIL required online forms is accurate and correct, including all electronic signatures. As guardian, I take full responsibility for reading and completing UIL forms with my child. The above student may receive a provided physical examination during school hours by a licensed provider unaccompanied by parent or guardian.

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 exam. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, game or match. 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's Name_______________ Gender____ Age_______ Date of Birth__________________

Height____________ Weight___________ Pulse __________ Blood Pressure _______/_________ (____/____ ,____/____)

Vision: R 20/_________ L 20/________ Corrected: ☐YES ☐NO Pupils: ☐ EQUAL ☐ UNEQUAL

As a requirement of Commerce ISD, this PHYSICAL EXAM FORM **must** be completed prior to athletic participation each year (7-12th grades).

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIAL*
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			
Sickle Cell Trait Testing*			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL			
Neck			
Spinal Screening			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

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 the State of Physician Assistant Examiners, a Advanced Practice Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination form signed by any other healthcare practitioners will not be accepted.

Name (Print): ______________________ Exam Date: ______________

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. All forms must be completed online at commerceisd2.atsusers.com