



This Medical History Form must be completed annually by parent (or guardian) and student, 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.

Students' Name (print) _____ Sex _____ Age _____ Date of Birth ____/____/____ Grade _____ School _____

Address _____ City _____ State _____ Zip _____ Student Mobile Phone _____

Personal Physician _____ Phone _____ Is student covered by health insurance? PRIVATE YES NO CHIP/MEDICAID YES NO

In case of an emergency contact: Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain YES answers in the box below. Circle questions that you do not know the answer to.

- 1. Have you had an illness or injury since your last check up or physical? YES NO
2. Have you been hospitalized in the past year? YES NO
Have you ever had surgery? YES NO

Heart/Cardiac

- 3. Have you ever had 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 ever 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 sudden unexplained death before the age of 50? YES NO
Has any family member ever 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? YES NO
Have you ever had a severe viral infection, such as myocarditis or mononucleosis, in the last month? YES NO
Has a physician ever denied or restricted your participation in activities for any heart problems? YES NO

Neurological

- 4. Have you ever had a head injury or concussion? YES NO
Have you ever been knocked out, become unconscious, or lost memory? YES NO
If yes how many times? _____
When was your last concussion? _____
How severe was each one? _____
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

General Medical

- 5. Are you missing any paired organs? YES NO
6. Are you currently under a doctor's care? YES NO
7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills? YES NO
8. Do you have any allergies? (pollen, medicine, food, stinging insects) YES NO
9. Have you ever gotten dizzy during or after exercise? YES NO
10. Do you have any current skin problems? (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 use an inhaler? YES NO
Do you have any allergies that require medical treatment? YES NO
14. Have you ever been diagnosed with or treated for sickle cell trait or disease? YES NO

Bones & Joints

- 15. Do you use any special protective or corrective equipment or devices that are not normally used for your activity or position? (EX, knee brace, special neck roll, foot orthotics, retainer for teeth, hearing aid, insulin pump) YES NO
16. Have you ever had a sprain, strain, or swelling after an injury? YES NO
Have you ever broken/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

Mental Health

- 17. Do you want to weigh either more/less than you do now? YES NO
18. Do you feel stressed out? 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 another? _____
How many periods have you had in the last year? _____
What was the longest time between periods next year? _____

Males Only

- 20. Do you have 2 testicles? YES NO
21. Do you have any testicular, swelling, lumps, or masses? YES NO

Electrocardiogram (ECG)

An electrocardiogram (ECG) is NOT required. I have read and understand the information about cardiac screening in the UIL Sudden Cardiac Arrest Awareness Form. The PSJA ISD Health Services Department offers ECG screens for a \$10.00 fee. I understand it is the responsibility of the family to pay for the ECG.

- YES - I would like to obtain an ECG for my student for additional cardiac screening
 NO - I decline an ECG for my student

Please explain any YES answers in the box below. 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, nurse practitioner, or chiropractor is required before any participation in UIL practices, games, or matches.

Empty box for explaining YES answers to questions 1, 2, 3, 4, 5, or 6.

- 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 judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, 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/injury should occur that may limit this student's participation, I agree to notify school authorities of the injury/ illness.

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:
School Official Name _____
Date _____
Signature _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful answers could subject the student in question to penalties determined by the UIL.
STUDENT SIGNATURE X _____
PARENT/GUARDIAN SIGNATURE X _____ DATE _____