2025-2026

TOMBALL ISD PRE-PARTICIPATION ATHLETIC FORM

ALL INFORMATION IS *REQUIRED* **DO NOT LEAVE ANY BLANKS **PRINT LEGIBLY WITH BLUE OR BLACK INK**

TISD Student ID # | Student's Last Name | Student's First Name | Student's Middle Initial | 2025-26 GRADE

Gender: _____

Date of Birth: _____

Check SCHOOL attending in 2025-26:

- ☐ TOMBALL HS
- ☐ TOMBALL MEMORIAL HS
- ☐ TOMBALL JH
- ☐ WILLOW WOOD JH
- ☐ CREEKSIDE PARK JH
- ☐ GRAND LAKES JH

Indicate sport(s) in which you plan to participate in: _____

PARENT/GUARDIAN 1: _____

Home Phone: _____

Cell Phone: _____

E-Mail Address: _____

PARENT/GUARDIAN 2: _____

Home Phone: _____

Cell Phone: _____

E-Mail Address: _____

Allergies to medication or other (please list): _____

Any medications taken regularly (please list): _____

Any medical concerns/conditions: _____

* Asthma Inhalers & EPI Pens: Additional TISD paperwork needed.

Sickle Cell/ Trait: NO / YES: _____

Diabetes: NO / YES: TYPE: _____

YES- Additional TISD Diabetic paperwork needed

Concussions: NO / YES: Dates _____

Epilepsy/ Seizure Disorder: NO / YES: _____

YES- additional TISD Seizure Management paperwork needed

CONSENT TO TREAT: It is understood that even though the athlete, whenever needed wears protective equipment, the possibility of an accident still remains. Neither the UIL nor Tomball ISD 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 because 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.

RELEASE TO RETURN TO PARTICIPATION AFTER ANY MEDICAL CONSULTATION: I understand that any student who seek medical attention from a HealthCare Provider for any injury or illness, regardless of whether they are removed from or have restrictions placed on their ability to participate, cannot return to athletic participation until a signed and dated physician's release has been provided to the Licensed Athletic Trainer (LAT) or designee. Parental authorization or notification will NOT be accepted in place of the medical release/note. This includes any injuries/ illness that may not be school related (Club/ off campus).

REQUIRED ONLINE FORMS & MEDICATION PERMISSION : Athletic paperwork and pre-participation forms for Tomball ISD are online. All 7th-12th grade prospective student-athletes must fill out UIL and TISD paperwork before they will be allowed to participate in any practice or contest before, during, or after school, including tryouts and athletics period. The website is designed to streamline the process, and conserve valuable resources. Go to TOMBALLISD.RANKONESPORT.COM and complete the Athletic Participation form which includes all mandatory UIL paperwork. Please have your student ID number available when filling out the paperwork.

******The TISD Physical Form must still be turned into an Athletic Trainer at the athlete's high school or respective coach at middle school.******

******This piece of paper must be dated, signed and stamped by the physician. The physical must also be signed by the parent, and student-athlete.******

Texas Licensed Athletic Trainers (LAT) of Tomball ISD are hereby given my acknowledgment and consent to administer non-prescription over-the-counter medication to my child. A complete list of over-the-counter medications is available from each campus upon request. I also give consent to administer prescription medication when prescribed by my child's physician and accompanied by appropriate TISD forms. The original prescription label must be on the container.

MEDICAL INFORMATION : Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians, school personnel and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Parent/Guardian Sign (required): _____ **Date:** _____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2025

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.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or 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?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart 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 unexplained death before age 50?	☐	☐
	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?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities 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 below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or 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.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
15.	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 appropriate box and explain below:		

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

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only I choose not to provide written information on Question 19 but will discuss with a medical professional: ☐

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 I choose not to provide written information on Question 20 but will discuss with a medical professional: ☐

20. Are you missing a testicle? _____
Do you have any testicular swelling or masses? _____

☐ 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.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

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 - MEDICAL EXAMINER SECTION

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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

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.