

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.

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): _____

Check "NO", "YES" or "DK" (Don't Know) If "Yes" explain on page 3 or, if needed, on a separate sheet of paper—please indicate the number of the question (shown on far left).

		NO	YES	DK
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?	☐	☐	☐
3	Have you ever had surgery?	☐	☐	☐
4	Have you ever had prior testing for the heart ordered by a physician?	☐	☐	☐
5	Have you ever passed out during or after exercise?	☐	☐	☐
6	Have you ever had chest pain during or after exercise?	☐	☐	☐
7	Do you get tired more quickly than your friends do during exercise?	☐	☐	☐
8	Have you ever had racing of your heart or skipped heartbeats?	☐	☐	☐
9	Have you had high blood pressure or high cholesterol?	☐	☐	☐
10	Have you ever been told you have a heart murmur?	☐	☐	☐
11	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐	☐
12	Has any family member 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?	☐	☐	☐
13	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐	☐
14	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐	☐
15	Have you ever had a head injury or concussion?	☐	☐	☐
16	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 on page 3)	☐	☐	☐
17	Have you ever had a seizure?	☐	☐	☐
18	Do you have frequent or severe headaches?	☐	☐	☐

continued on next page

PREPARTICIPATION PHYSICAL EVALUATION — MEDICAL HISTORY *continued*

		NO	YES	DK
19	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐	☐
20	Have you ever had a stinger, burner, or pinched nerve?	☐	☐	☐
21	Are you missing any paired organs?	☐	☐	☐
22	Are you under a doctor's care?	☐	☐	☐
23	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐	☐
24	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐	☐
25	Have you ever been dizzy during or after exercise?	☐	☐	☐
26	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐	☐
27	Have you ever become ill from exercising in the heat?	☐	☐	☐
28	Have you had any problems with your eyes or vision?	☐	☐	☐
29	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐	☐
30	Do you have asthma?	☐	☐	☐
31	Do you have seasonal allergies that require medical treatment?	☐	☐	☐
32	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)?	☐	☐	☐
33	Have you ever had a sprain, strain, or swelling after injury?	☐	☐	☐
34	Have you broken or fractured any bones or dislocated any joints?	☐	☐	☐
35	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <i>If yes, check appropriate box and explain on separate page:</i> ☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hip ☐ Thigh ☐ Knee ☐ Hand ☐ Shin/Calf ☐ Finger ☐ Ankle Foot	☐	☐	☐
36	Do you want to weigh more or less than you do now?	☐	☐	☐
37	Do you feel stressed out?	☐	☐	☐
38	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐	☐
39	Females Only: • 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? _____			
40	Males Only: • Do you have two testicles? • Do you have any testicular swelling or masses?	☐	☐	☐
An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions 4 through 12, page 1), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner. **ALL 'YES' ANSWERS please explain on the following page (attach another sheet if necessary).				

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PREPARTICIPATION PHYSICAL EVALUATION — MEDICAL HISTORY *continued*



Please explain all “YES” answers below or, if needed, on a separate sheet of paper—please indicate the number of the question (shown on far left).

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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 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 the UIL.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____

Any "YES" answers to questions 1 through 22 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: _____

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION



Student's Name: (print) _____ Sex: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ % Body fat (optional): _____ Pulse: _____ BP: ____/____ (____/____, ____/____)

Brachial blood pressure while sitting

Vision: R 20/ _____ L 20/ _____ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

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 student's **MEDICAL HISTORY FORM**.

Local district policy may require an annual physical exam (station-based examination only).

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance	☐		
Eyes / Ears / 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 stimata (arachnodactyly, pectus exavatum, joint hypermobility, scoliosis)	☐		
MUSCULOSKELETAL			
Neck	☐		
Back	☐		
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 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) _____ Date of Exam: _____

Address: _____ Phone: _____ Cell: _____

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.