2025 - 2026 MEDICAL HISTORY & PREPARTICIPATION PHYSICAL EVALUATION FORM

STUDENT NAME:_____ **SEX:**___ **BIRTHDAY:**_____**STUDENT ID #**_____**SCHOOL (25-26)**_____ **GRADE (25-26):** _____

Height _____Weight_____% Body fat (optional) ____ Pulse _____ BP____/____ (___/___, ___/___) Vision R 20/____ L 20/____ Corrected: ☐Y ☐N Pupils: ☐Equal ☐Unequal
brachial blood pressure while sitting

PREPARTICIPATION PHYSICAL EXAMINATION – MEDICAL HISTORY REVISED 2024

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.
Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

1. Have you had a medical illness or injury since your last check up or physical? Yes☐ No☐
2. Have you been hospitalized overnight in the past year? Yes☐ No☐
   Have you ever had surgery? Yes☐ No☐
3. Have you ever had prior 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 of sudden unexpected death before age 50? Yes☐ No ☐
   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? Yes☐ No☐
   Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes☐ No☐
   Has a physician ever denied or restricted your participation in activities for any heart problems? Yes☐ No☐
4. Have you ever had a head injury or concussion? Yes☐ No☐
   Have you ever been knocked out, become unconscious, or lost your memory? Yes☐ No☐
   If yes, how many times?___ When was your last concussion? _____How severe was each one? Explain below
   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☐
5. Are you missing any paired organs? Yes☐ No☐
6. Are you under a doctor's care? Yes☐ No☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? Yes☐ No☐
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Yes☐ No☐
9. Have you ever been dizzy during or after exercise? Yes☐ No☐
10. Do you have any current skin problems (for example, 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 have seasonal allergies that require medical treatment? Yes☐ No☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or activity (for example, knee brace,special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes☐ No☐
15. Have you ever had a sprain, strain, or swelling after injury? Yes☐ No☐
    Have you broken or 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 ☐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? Yes☐ No☐
17. Do you feel stressed out? Yes☐ No☐
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease. Yes☐ No☐

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? _____ How much time do you usually have from the start of one period to the start of another? _____What was the longest time between periods in the last year? _____

Males Only:
☐ I choose not to provide written information on question 19 but will discuss with a medical professional
20. Are you missing a testicle? _____ 21.Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening in 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

PREPARTICIPATION PHYSICAL EVALUATION -PHYSICAL EXAMINATION

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.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
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)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE (TO BE COMPLETED BY PHYSICIAN)

☐**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) _____
Address: _____
Phone Number: _____
Physician Signature: _____
DATE OF EXAMINATION: _____ ***must be dated on or after April 30, 2025***

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.

******FINAL STEP******

Submit this completed physical form online and complete all other required electronic forms at georgetownisd.rankone.com

If you are experiencing any difficulties submitting the completed physical form online, please submit this form to the following:

EVHS/TMS/WMS STUDENTS EMAIL FORM TO EVHSTRAINERS@GEORGEOWNISD.ORG

GHS/BMS/FMS STUDENTS EMAIL FORM TO GHSTRAINERS@GEORGETOWNISD.ORG

IF SUBMITTING PHYSICAL VIA EMAIL, THE REMAINING ELECTRONIC FORMS WILL STILL NEEDTO BE SUBMITTED AT GEORGETOWNISD.RANKONE.COM

2025-2026