

TAPPS MEDICAL HISTORY FORM

This Medical History Form must be completed annually by the parent (or guardian) and student in order for the student to participate in TAPPS athletic and selected fine art activities. These questions are designed to assist the practitioner in determining if the student has developed any condition which would make it hazardous to participate in an extracurricular activity.

STUDENT NAME: _____ **GRADE LEVEL:** 9 10 11 12
GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** ____/____/_____
HOME ADDRESS: _____ **CONTACT PHONE #:** (____) ____-_____
PERSONAL PHYSICIAN: _____ **PHYSICIAN PHONE #:** (____) ____-_____

If the answer to any question is yes, please discuss the circumstances with your provider at the time of the physical examination.

	YES	NO	UNKNOWN
Have you had a medical illness or injury since your last physical?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had prior testing ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your racing of your heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your heart skip beats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any member of your biological family died of heart problems or sudden unexplained death prior to the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any biological family member been diagnosed with an enlarged heart (dilated Cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion Channelopathy (Brugada Syndrome, etc), Marfan's Syndrome or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	YES	NO	UNKNOWN
Has a physician ever denied or restricted your participation in extracurricular activities for any heart related problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a diagnosed head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost memories?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to the question above, how many times? _____			
If yes, when was your last diagnosed concussion? __/__/____			
If Yes, how severe were each of the concussions? Discuss with the Provider			
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been unexpectedly short of breath while exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed by a physician with asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies which require medical attention or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under a doctor's care for any condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or nonprescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently using an inhaler, prescribed or nonprescribed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known allergies (pollen, medicine, food or insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have current skin problems (examples: itching, rashes, acne, warts, blisters or fungus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to weigh more or less than you do today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with or treated by a physician for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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YES NO UNKNOWN

Do you use any special protective or corrective equipment that are not usually used for your particular activities (examples: knee brace, neck roll, foot orthotics, retainer, prescription goggles or hearing aid)?

☐ ☐ ☐

Have you ever had swelling after a sprain, strain or injury?

☐ ☐ ☐

YES NO UNKNOWN

Have you ever 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, please check each box below that applies.

HEAD	<input type="checkbox"/>	ELBOW	<input type="checkbox"/>	HIP	<input type="checkbox"/>
NECK	<input type="checkbox"/>	FOREARM	<input type="checkbox"/>	THIGH	<input type="checkbox"/>
BACK	<input type="checkbox"/>	WRIST	<input type="checkbox"/>	KNEE	<input type="checkbox"/>
CHEST	<input type="checkbox"/>	HAND	<input type="checkbox"/>	SHIN / CALF	<input type="checkbox"/>
SHOULDER	<input type="checkbox"/>	FINGER	<input type="checkbox"/>	ANKLE	<input type="checkbox"/>
UPPER ARM	<input type="checkbox"/>	FOOT	<input type="checkbox"/>		

Female Students Only (If left blank I agree to provide such information to the provider at the time of examination)

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? _____ days

What was the longest time between periods in the last year? _____ days

How many periods have you had in the last year?

Male Students Only (If left blank I agree to provide such information to the provider at the time of examination)

Are you missing a testicle? YES NO

Do you have any testicular pain? YES NO

Do you have any testicular swelling or masses? YES NO

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It is understood that even though protective equipment is worn by the student participant, whenever needed and as prescribed, the possibility of accident or injury still remains. Neither the Texas Association of Private and Parochial Schools (TAPPS) nor the TAPPS member school assumes any responsibility should injury occur.

If in the judgement of any representative of the school the student should need immediate care and / or 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 to said student by any physician, athletic trainer, nurse or designated school representative. I do hereby indemnify and save harmless the TAPPS member school, TAPPS, treating medical establishment and representatives of each from any claim by any on account of such care and treatment of said student.

If, between the date affixed to this document and the beginning of extracurricular training, competition, or performance any injury or illness should occur that may limit the student's participation, I agree to promptly notify the recognized and designated authority at the member school of such injury or illness.

I hereby state that to the best of my knowledge, my answers to the questions asked on this form are complete and correct. I understand that failure to provide truthful and complete responses could subject the student to nonparticipation at the member school and penalties as determined by TAPPS.

Student Full Name: _____

Student Signature: _____

Date of Signature: ____ / ____ / ____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date of Signature: ____ / ____ / ____

PREVIOUS ATHLETIC PARTICIPATION FORM (PAPF)

Student Full Name: _____

Student Present Street Address: _____

Previous Schools attended in Last 12 Months: _____

Grades Attended at the Previous School: _____ Grade attending at the current school: _____

Date of first attendance at the current school: _____ Date withdrew from the previous school: _____

PART A - Certification of Family:

We certify that neither my child nor I have been offered nor accepted any inducement to attend the new school in accordance with Section 87 of the TAPPS By-Laws. We certify that my child is in compliance with all TRANSFER policies as outlined in **Section 104** of the TAPPS By-Laws. The new school has presented information regarding TAPPS eligibility for our review prior to signature of this document. If unsure of compliance, please consult your school's Athletic Director prior to signature.

Parent Signature / Date: _____ Student Signature / Date: _____

PART B - Certification of Nonparticipation at Previous School

- ☐ We certify that our child did not participate (tryout, practice or compete) in any level of athletics at the previous school. Skip Part C below and return to current school if no previous participation.

PART C - Certification of Participation by Previous School

1. ☐ **Yes** ☐ **No** Was this student ever suspended or removed from an athletic program in your school?
2. ☐ **Yes** ☐ **No** Would the student have been prohibited from athletic participation at the previous school?
3. ☐ **Yes** ☐ **No** Is the previous school an alternative school in which the student was placed?
4. ☐ **Yes** ☐ **No** Based on your knowledge, did the student participate on any AAU, club or similar team coached by a coach or faculty member at the new school?
5. ☐ **Yes** ☐ **No** Based on your knowledge, did the student participate on any off-season league team coached by a coach or faculty member at the new school?
6. ☐ **Yes** ☐ **No** Based on your knowledge, did the student participate in a camp or camps involving the new school or a coach or faculty member at the new school?
7. ☐ **Yes** ☐ **No** Based on your knowledge, did the student receive private or group training by a coach or faculty member at the new school?
8. ☐ **Yes** ☐ **No** Based on your knowledge did the student receive any offer of inducement, financial or otherwise, to attend the new school?

Administrator / Date: _____ Athletic Director / Date: _____

PART D - Certification of the Current School:

We certify that to the best of our knowledge, no one has offered any inducement to the student or parent to transfer to our school and we certify that the student was not induced. We reviewed all information and circumstances pertaining to this student's transfer to our school and certify that all TAPPS By-Laws have been upheld. The new school has presented information regarding TAPPS eligibility to the student and parents for review prior to signature of this document. We acknowledge that the student is not eligible for interscholastic competition at any level until the Transfer Approval process is completed and approval from TAPPS.

Administrator / Date: _____ Athletic Director / Date: _____

TAPPS PREPARTICIPATION PHYSICAL EVALUATION

STUDENT'S FULL NAME: _____ **GRADE LEVEL:** 9 10 11 12
GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** ____/____/_____
HEIGHT: ____feet ____inches **WEIGHT:** _____ **% BODY FAT:** _____%
PULSE: _____ **BLOOD PRESSURE:** ____/____ **BRACHIAL BP WHILE SITTING:** ____/____, ____/____

In keeping with the requirements of the Texas Association of Private and Parochial Schools (TAPPS), the physical examination form must be completed prior entrance to high school and prior to athletic participation each year. The form is good for one year from the date of physician signature shown below.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart – Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hyper mobility, or scoliosis)			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other as noted			

*station-based examination only

Clearance:

- ☐ Cleared for all participation.
☐ Cleared after completing rehabilitation / examination for: _____
☐ Not cleared for: _____ Reason: _____

Recommendations:

Provider Name: _____ Provider Address: _____

Provider Signature: _____ Date of Examination: ____ / ____ / ____

TAPPS STUDENT TRANSFER FORM (STF)

Student Full Name: _____
Gender on Birth Certificate: _____ Date of Birth: _____ Grade Level: 9 10 11 12

Education Information

Name of New School: _____
Name of School first enrolled in for ninth grade? _____
Date of enrollment in the ninth grade at first school (month/year)? _____

Financial Aid:

___ Yes ___ No Was the student receiving financial aid at the previous school?
___ Yes ___ No Is the student receiving financial aid at the new school?

Who is paying for student's tuition at the new school? (ie parents, other)

Participation:

Please circle each of the activities in which the student plans to participate at the new school.

Baseball	Basketball	Cross Country	Fall Soccer	Fine Arts	Football	Golf
Softball	Swimming	Tennis	Track and Field	Volleyball	Winter Soccer	Wrestling

Please list each of the activities in which the student participated at the previous school and the level at which they participated (ie. Varsity, Sub varsity, practice or tryout): _____

Eligibility:

___ Yes ___ No	Has the student missed class time to participate in national or international competition?
___ Yes ___ No	Has the student been suspended or dismissed from the previous school?
___ Yes ___ No	Is the student presently suspended from the previous school?
___ Yes ___ No	Is the student eligible to return to the previous school?
___ Yes ___ No	Did the student participate in AAU, club, or select teams prior to applying at the new school?
___ Yes ___ No	Has the student participated on an AAU, club, or select team coached, managed, or owned by any member of the coaching staff or faculty at the new school?
___ Yes ___ No	Has the student participated on an AAU, club, or select team on which other students at the new school participated?
___ Yes ___ No	Did the student participate on a "fall" or "spring" team for the new school prior to enrollment?
___ Yes ___ No	Did the student participate on a "fall" or "spring" team coached by a member of the coaching staff or faculty at the new school prior to enrollment?
___ Yes ___ No	Did the student participate on a "summer" team for the new school prior to attendance?
___ Yes ___ No	Did the student participate on a "summer" team coached by a member of the coaching staff or faculty at the new school?
___ Yes ___ No	Did the student participate in 7 on 7 with the previous school prior to withdrawal?
___ Yes ___ No	Did the student participate in 7 on 7 with the new school prior to the last day of school at the previous school?
___ Yes ___ No	Did the student participate in 7 on 7 or similar teams during the summer with the new school?
___ Yes ___ No	Did the student receive private instruction from a member of the staff at the new school?
___ Yes ___ No	Did the student attend any camp held by or at the new school prior to enrollment?

By signature below, we attest that the above information is factual, true and correct. We understand that if information is later determined to be incorrect or untrue, the eligibility of the student would be in jeopardy and any contests in which the student participated would be subject to forfeiture by the school.

Student Signature /Date

Parent or Guardian Signature /Date

Effective 06/01/2024