

Please Print in Box

School: _____

Student Name: _____

**Confirmation of Understanding of Limited Scope and Purpose of the
 Extra-Curricular/Co-Curricular Pre-Participation Physical Exams**

I, _____, (Print Parent/Legal Guardian Name) am aware that my child/ward,
 _____ (Print Child's Name), will attend an event providing pre-participation physical exams for
 student athletes at _____ on _____, _____, 20__ ("the event"). The event is sponsored and provided by
 Houston Methodist ("Houston Methodist") for the sole purpose of clearing students for participation in extra-curricular/co-
 curricular programs. The screening physical exam will be performed by volunteer healthcare providers. By signing this form, I
 am confirming I understand and agree to the following:

- **I consent to the extra-curricular/co-curricular physical exam for the above-named child.**
- This is **NOT** a comprehensive physical exam and should not take the place of routine medical care; I understand that this is a **screening physical for clearance for participation in extra-curricular/co-curricular activities ONLY**;
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- I understand that my child may need additional testing before he/she can be cleared for participation in athletic activities and it is my sole responsibility to obtain such additional testing or medical care: I understand that if it is determined that my child needs additional medical treatment; I will be notified of any such recommendation. I understand that a limited number of non-invasive tests may be available and performed at the event for my convenience; **I consent to any and all additional non-invasive testing as deemed necessary by the screening physician during the event without notification to me prior to the testing**;
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event. This consent is valid for 180 days and I understand that I may revoke this consent at any time. I understand that the information released may not be protected under the law once it is disclosed and may be subject to re-disclosure by the Recipient.

 Parent/Guardian's Signature

 Date

RELEASE FROM LIABILITY AND INDEMNIFICATION

I hereby release, waive, discharge and covenant not to sue Houston Methodist and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the extra-curricular/co-curricular Physical Examination Event.

I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in the Release.

 Parent/Guardian's Signature

 Date

Print Name: _____



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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 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		Yes	No
1. Have you had a medical illness or injury since your last check up or physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Has a physician ever denied or restricted your participation in activities for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			21. Have you been diagnosed with a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____			22. Have you been diagnosed as a Type I or Type II diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			<i>Females Only</i>		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	23. When was your first menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	24. When was your most recent menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	25. How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	26. How many periods have you had in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	27. What was the longest time between periods in the last year? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

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. Duchesne Academy of the Sacred Heart does not assume 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, school representative or official healthcare provider. 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 Duchesne Academy of the Sacred Heart.

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, or nurse practitioner is required before any participation in Duchesne Academy 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

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ Pulse _____ BP _____ / _____ (____/____, ____/____)
 Vision: R: 20/____ L: 20/____ Corrected: Y____ N____ Pupils: Equal____ Unequal____

As a minimum requirement, this Physical Examination Form must be completed prior to each year of high school before a student participates in any practice (before, during or after school), in season or out of season, games, matches or competitions.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the 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 hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

- Cleared for all sport activity
- 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, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner, **or parent who is a Healthcare Provider, will not be accepted.**

Name _____ Date of Examination _____

Address _____

Phone Number _____ Signature _____