

L.D. Bell High School

**Mike Stokic LAT, EMT * 1601 Brown Trail * Hurst, Tx. 76054
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Sports Medicine

Dear HEB Parents,

On Friday, May 17th, the athletic training department of L. D. Bell High School will sponsor low cost athletic physicals. The cost will be \$10.00 and the proceeds will be donated to the student athletic training program. These physicals will fulfill UIL requirements to participate in high school sports for the 2019-20 school year. Physicals will be conducted in the E. Don Brown Athletic facility. Checks need to be made out to L.D. Bell High School.

We have arranged for 4-6 doctors, who work directly with L.D. Bell High School sport's programs, to perform the physicals. To facilitate a smooth execution, please have the student information, medical history, parent and student signatures in place on the physical form. Students will need to bring this form with them with the day of the physicals.

Students will not be allowed to get their physical without all parental signatures and medical history filled in.

The Jr High coaches will bus their respective students to Bell High School during the afternoon athletic period and will return to the appropriate Jr High when finished. Parents can also pick up their children if they wish.

We will try to start at 3:00 PM and proceed until finished. We ask that all individuals be at the high school main gym as close to 3:00 as possible so we can begin promptly .

If any disqualifying factors are found, you will be contacted so you can follow-up with your family doctor for further evaluation and clearance to participate.

We hope this will be a convenient and economical way for your son or daughter to get a participation physical. If you have any questions please contact your child's coach or call me at school.

Sincerely,

Mike Stokic LAT, EMT
Athletic Trainer
L.D. Bell High School
817-399-3241

Here we go!

On Friday, May 17th we will provide the opportunity for our kids to get a low cost athletic physical.

Here is what you need to know and how to help.

Cost: \$10:00 cash or checks made out to L.D. Bell High School

Where: Bell HS (E. Don Brown Athletic facility.)

Time: We will try to start at 3:00 and go until finished.

Have Athletes Wear: Shorts, T-shirts, Tennis Shoes

Form: Current HEBISD physical form only please! (**White Paper Form 2019-2020**)
Other forms WILL NOT BE ACCEPTED!!!

Who: All Those Wanting To Participate in HEBISD Athletics for the 2019-20 School Year. This includes incoming 7th graders.

We ask that Jr. High coaches provide transportation of the Jr. High athletes to Bell & back as needed. Parents may pick up their kids from Bell if desired.

We need at least 1 male and 1 female Jr High Coach to help in supervising and some chaperoning during physicals may be needed.

Have each student complete all **HIGHLIGHTED** personal information, medical history, parent and student signatures in place before they arrive for their physical.

STUDENT WILL NOT BE ALLOWED TO GET THEIR PHYSICAL WITHOUT THIS BEING COMPLETED & SIGNATURES IN PLACE, ESPECIALLY THE MEDICAL HISTORY PORTION.

Have students write in the grade they will be in for the **2019-20** school year!

Please have the athletes **"PRINT" neatly and clearly in INK only.**

I have attached a copy of the new forms for you to print and run off copies.

Thanks for your help in this.

Mike Stokic

Bert Sanchez

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HEB-ISD Pre-Participation Medical History 2019-20120 School Year

This **MEDICAL HISTORY FORM** must be completed annually by parent (or guardian) and the student to participate in athletic or band 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 Name _____ Sport _____ Date Of Birth _____
 Street Address _____ City _____ Zip _____
 Mother's Name _____ Home # _____ Work# _____ Cell# _____
 Father's Name _____ Home # _____ Work# _____ Cell# _____
 Emergency Contact _____ Home # _____ Work# _____ Cell# _____
 2019-20 Grade _____ 2019-20 School Attending _____ Current Age _____ Expected Year of Graduation _____ Sex: M F

A "yes" on questions 1,2,5,7,11, or 16 requires a 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 ANY PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE, OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

Explain "Yes" answers on a separate sheet of paper. Circle questions you do not know the answer to.

	Y	N		Y	N	
1. Have you had a medical illness or injury since you last physical?			11. Missing any paired organ's ?Have any testicle swelling or masses?			
2. Have you been hospitalized overnight in the past year? Surgeries?			Have Two Testicles?			
3. Are you currently taking any prescription or over-the-counter medications or pills, or using an inhaler?			12. Do you use any special protective or corrective equipment or devices that aren't used for your sport or position? Braces, neck roll orthotics hearing aid. Retainer?			
4. Do you have any allergies to medications, pollen, food, or insect bites?			13. Have you ever experienced: A sprain, strain or swelling after an injury?			
5. Have you ever: Passed out during or after exercise?			Broken any bones or dislocated any joints?			
Been dizzy before or after exercise?			Pain or swelling in muscles, tendons, bones, or joints?			
Had chest pain during or after exercise?			If yes, circle the area and explain below. Head Elbow Chest Hand Hip Neck Forearm Shoulder Finger Thigh Back Wrist Shin/Calf Foot Knee Ankle Upper Arm			
Get tired more quickly than your friends during or after exercise?						
Experienced a racing heartbeat or skipped heartbeat?						
Had high blood pressure or high cholesterol?						
Diagnosed with a heart murmur?						
Had a family member die of a heart problems or unexpected death before age 50?				14. Do you want to weigh more or less than you do now?		
Had any family member 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?				Do you lose weight to meet requirements for you sport?		
Had prior testing for the heart ordered by a physician?				15. Do you feel stressed out?		
Had a severe viral infection (mono, myocarditis) within the last month?				16. Are you under a doctor's care?		
Has a physician denied or restricted participation in sports for any heart problems?				17. Have you ever been diagnosed with or treated for sickle cell trait or cell disease?		
6. Have any current skin problems (rashes, acne, warts, fungus, or blisters)?			18. Females Only: When was your first menstrual period? _____ When was your most recent menstrual period? _____ Usual time between periods? _____ How many periods have you had in the last year? _____ What was the longest time between periods within the last year? _____			
7. Have you ever: Had a head injury or concussion? Been knocked out, become unconscious, or lost your memory?			Explain any "YES" answers here. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
If yes, how many times _____ When was the last concussion _____						
How severe? Explain Below						
Had a seizure?						
Have frequent or severe headaches?						
Had numbness or tingling in your arms, hands, legs, or feet?						
Had a stinger, burner, or pinched nerve?						
8. Have you ever become ill from exercising in the heat?						
9. Have you ever gotten unexpectedly short of breath while exercising?						
Do you have asthma?						
Do you have seasonal allergies that require medical treatment?						
10. Have you had any problems with your eyes or vision?			Use a separate sheet of paper if needed.			

An individual answering in the affirmation to any question relating to a possible cardiovascular health issue (question 5 above), 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.

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct.
 Failure to provide truthful response on any UIL forms could subject the student in question to penalties determined by the UIL.

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.

Parent/Guardian Signature _____ **Student Signature** _____ **Date** _____
Official School Use Only: Medical History Form was reviewed by School Official:
 Printed Name of School Official _____ Date _____ Signature _____

Printed Student Name _____

HEB-ISD Pre-participation Physical Examination

HEIGHT _____ WEIGHT _____ % BODY FAT (Optional) _____ 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 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 on the front side. *Local district policy may change to where an annual physical exam may be required.
HEBISD requires annual physicals.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart–Auscultation supine			
Heart–Auscultation standing			
Heart–Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Cleared _____

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared For: _____

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.

Physician Name (print/type) _____ Date of Examination _____

Address _____ Phone # _____

Physician Signature _____