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, PERFORMNCE, 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
1. Have you had a medical illness or injury since you last physical?		
2. Have you been hospitalized overnight in the past year? Surgeries?		
3. Are you currently taking any prescription or over-the-counter medications or pills, or using an inhaler?		
4. Do you have any allergies to medications, pollen, food, or insect bites?		
5. Have you ever: Passed out during or after exercise?		
Been dizzy before or after exercise?		
Had chest pain during or after exercise?		
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?		
Had any family member diagnosed with enlarged heart,		
(dialated cardiomyopathy) **hypertrophic** cardiomyopathy, long QT syndrome or other ion channelpathy(Brugada syndrome etc.) Marfan's syndrome, or abnormal heart- rhythm?		
Had prior testing for the heart ordered by a physician?		
Had a severe viral infection (mono, myocarditis) within the last month?		
Has a physician denied or restricted participation in sports for any heart problems?		
6. Have any current skin problems (rashes, acne, warts, fungus, or blisters)?		
7. Have you ever: Had a head injury or concussion?		
Been knocked out, become unconscious, or lost your memory?		
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?		

	Y	N
11. Missing any paired organ's ?Have any testicle swelling or masses?		
Have Two Testicles?		
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?		
13. Have you ever experienced: A sprain, strain or swelling after an injury?		
Broken any bones or dislocated any joints?		
Pain or swelling in muscles, tendons, bones, or joints?		

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**			

	Y	N
14. Do you want to weigh more or less than you do now?		
Do you lose weight to meet requirements for you sport?		
15. Do you feel stressed out?		
16. Are you under a doctor's care?		
17. Have you ever been diagnosed with or treated for sickle cell trait or cell disease?		

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? _________

Explain any "YES" answers here.

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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 ClearedFor:____

Recommendations:____

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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____