

**STUDENT NAME (LAST, FIRST)** \_\_\_\_\_  
**STUDENT ID#** \_\_\_\_\_ **GRADE (2023-24)** \_\_\_\_\_

## PREPARTICIPATION PHYSICAL EVALUATION-MEDICAL HISTORY

Please answer each question by circling "YES" or "NO". If you do not know the answer circle the question.

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|--|-----|----|
| 1. Have you had a medical illness or injury since your last check up or sports 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 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 or 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 channelopathy (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 sports 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 the 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 (to pollen, strain, 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 (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 position (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 |
| Do you lose weight regularly to meet weight requirements for your sport?   | 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*

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? \_\_\_\_\_  
 What was the longest time between periods in the last year? \_\_\_\_\_

**Males Only**

20. Do you have two testicles? \_\_\_\_\_
21. Do you have any testicular swelling or masses? \_\_\_\_\_

**\*Explain "Yes" answers here:** A "yes" on questions 1, 2, 3, 4, 5, or 6 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 PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

It is understood that even though protective equipment is worn by the athlete, 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 athletic competition, 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.

Parent Signature: \_\_\_\_\_

Student Signature: \_\_\_\_\_

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

## PREPARTICIPATION PHYSICAL EVALUATION- PHYSICAL EXAMINATION

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 students Medical History Form. **Leander ISD requires annual completion of this form.**

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 pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Height	Weight	%Body Fat	Pulse	BP	/
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Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat \_\_\_\_\_ Pulse \_\_\_\_\_  
( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )-brachial blood pressure while sitting

**Vision** R 20/ L 20/ Corrected: Y N **Pupils:** Equal OR Unequal

**CLEARANCE {Please check one}**

☐ Cleared (No restrictions)☐ 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.

Physician Name (print/type):

Address: \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**FOR LISD SCHOOL OFFICIAL USE ONLY:**

*This medical history form was reviewed by:*

Printed Name: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_