# STUDENT NAME (LAST, FIRST) PREPARTICIPATION PHYSICAL EVALUATION-MEDICAL HISTORY

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

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

1. 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 channelpathy (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

2021-2022

heart problems? YES NO

1. 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

1. Are you missing any paired organs? YES NO
2. Are you under a doctor’s care? YES NO
3. Are you currently taking any prescription or non-prescription

(over the counter) medication or pills or using an inhaler YES NO

1. Do you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO
2. Have you ever been dizzy during or after exercise YES NO
3. Do you have any current skin problems (itching, rashes, acne, warts

fungus, or blisters)? YES NO

1. Have you ever become ill from exercising in the heat? YES NO
2. Have you had any problems with your eyes or vision? YES NO
3. 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

1. 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

1. 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

1. 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
2. Do you feel stressed out? YES NO
3. Have you ever been diagnosed with or treated for sickle cell trait or

Sickle cell disease? YES NO

### Females Only

1. When was your first menstrual period?

**box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.**

**An electrocardiogram (ECG) is not required. By checking this**

# 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. The **FWISD requires annual completion of this form.**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINIDINGS** | **INITIALS** |
| Appearance |  |  |  |
| Eyes/Ears/Nose/Throat |  |  |  |
| Lymph Nodes |  |  |  |
| Heart-Auscultation of the heart in the supineposition |  |  |  |
| Heart-Auscultation ofthe heart in the standing position |  |  |  |
| Heart-Lower extremity pulse |  |  |  |
| Pulses |  |  |  |
| Lungs |  |  |  |
| Abdomen |  |  |  |
| Genitalia (males only) |  |  |  |
| SkinMarfan’s Stigmata |  |  |  |
| **MUSCULOSKELETAL** |  |  |  |
| Neck |  |  |  |
| Back |  |  |  |
| Shoulder/Arm |  |  |  |
| Elbow/Forearm |  |  |  |
| Wrist/Hand |  |  |  |
| Hip/Thigh |  |  |  |
| Knee |  |  |  |
| Leg/Ankle |  |  |  |
| Foot |  |  |  |

Height Weight %Body Fat Pulse BP / ( / , / )-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*:*

When was your most recent menstrual period? \_

**Reason**:

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

1. Do you have two testicles?
2. 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,gamesormatches)**\_**

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:** \_

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE 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.

|  |
| --- |
|  |
| ***FOR SCHOOL USE ONLY***: |
| *This medical history form was reviewed by:***Printed Name**: **Signature**: **Date**:  |

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.

**Phone Number:** \_ **Physician Signature**

**Date:** \_

Parent Signature: Student Signature: