

**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

Revised 1/11/06

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition that would make it hazardous to participate in an athletic event.

Student's Name: \_\_\_\_\_ Sex \_\_\_\_\_ Student ID# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

**Emergency Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_ Policy # \_\_\_\_\_

Explain "Yes" answers below. Circle questions you don't know the answers to. Any "Yes" answer to questions 1, 2, 5, 7, 11, or 17 requires further medical evaluation which may include a physical examination. See below \*.

- |  | Yes                      | No                       |   | Yes                      | No                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?   | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year?<br>Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you missing any paired organs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. 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"/> | 12. 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)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had a sprain, strain, or swelling after injury?<br>Have you broken or fractured any bones or dislocated any joints?<br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you get tired more quickly than your friends do during exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Have you had high blood pressure or high cholesterol?<br>Have you ever been told you have a heart murmur?<br>Has any family member or relative died of heart problems or of sudden unexpected death before age 50?<br>Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?<br>Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?<br>Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below.  |                          |                          |
| 6. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip   |                          |                          |
| 7. Have you ever had a head injury or concussion?<br>Have you ever been knocked out, become unconscious, or lost your memory?<br>If yes, how many times? _____ When was the last concussion? _____<br>How severe was each one? (Explain below)<br>Have you ever had a seizure?<br>Do you have frequent or severe headaches?<br>Have you ever had numbness or tingling in your arms, hands, legs, or feet?<br>Have you ever had a stinger, burner, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh   |                          |                          |
| 8. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee  |                          |                          |
| 9. Have you ever gotten unexpectedly short of breath with exercise?<br>Do you cough, wheeze or have trouble breathing during or after activity?<br>Do you have asthma?<br>Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf   |                          |                          |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle  |                          |                          |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot  |                          |                          |
|  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you want to weigh more or less than you do now?<br>Do you lose weight regularly to meet weight requirements for your sport?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you feel stressed out?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Record the dates of your most recent immunizations (shots):<br>Tetanus _____ Measles _____<br>Hepatitis B _____ Chickenpox _____  |                          |                          |
|  | <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you under a doctor's care?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | <b>Females Only</b>   |                          |                          |
|  |                          |                          | 18. 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? _____   |                          |                          |
|  |                          |                          | <i>* Explain "Yes" answers here: (A "yes" on questions 1, 2, 5, 7, 11 or 17 requires a further medical explanation which may include a physical examination. Written clearance from a physician, physical assistant or nurse practitioner is required before any participation in UIL practices, games or matches.)</i> |                          |                          |

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (#5 above), as identified on the form, should be restricted from further participation until the individual is examined by the individual's primary care physician. Ultimately, the individual may need to be evaluated by a cardiologist and/or undergo cardiac testing (including an echocardiogram and/or other heart-related examination) based on the assessment by the primary care physician.

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 high 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.

- To the Parent:**  Baseball  Football  Softball  Tennis  Wrestling  
**Check any activity this student should be excluded from.**  Basketball  Golf  Swimming & Diving  Track & Field  
 Cross Country  Soccer  Team Tennis  Volleyball

**THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

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 in question to penalties determined by the UIL.  
 Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student ID#

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Student's Name Sex Age Date of Birth
Height Weight % Body Fat (Optional) Pulse BP ( / , / )
Vision: R 20/ L 20/ Corrected: Y N Pupils: Equal Unequal

RISD Policy requires an annual physical exam prior to junior high and high school athletic participation.

Table with 4 columns: MEDICAL, NORMAL, ABNORMAL FINDINGS, INITIALS \*. Rows include 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 pulses, Pulses, Lungs, Abdomen, Genitalia (males only), Skin, MUSCULOSKELETAL, Neck, Back, Shoulder/Arm, Elbow/Forearm, Wrist/Hand, Hip/Thigh, Knee, Leg/Ankle, Foot.

- Station-Based Examination Only

CLEARANCE

- Cleared
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, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.
Physician's Name (print/type) Date of Examination
Address Phone #
Signature

\* Must be completed before a student participates in any practice or games/matches: before, during or after school (both in-season and out-of-season).