Medical History (Revised 2017)

PSJA STUDENT ID NUMBER _____

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 which would make it hazardous to participate in an athletic event.

Student Name (print) _____ Sex M / F Age _____ Date of Birth _____/_____/_____ Grade _____ School _____

Address _____ City _____ State _____ Zip _____ Student Mobile Phone _____

Physician Name _____ Phone _____ Is the student covered by health insurance? PRIVATE ☐ YES ☐ NO CHIP/MEDICAID ☐ YES ☐ NO

In case of emergency contact: Parent/Guardian Name _____ Relationship_____ Phone (H) _____ (W) _____

Explain **"YES"** answers in the box below** Circle questions you don't know the answer to

		YES	NO
1.	- Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	- Have you ever been hospitalized overnight in the last year?	☐	☐
	- Have you ever had surgery?	☐	☐
3.	- Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	- Have you ever passed out during or after exercise?	☐	☐
	- Have you ever had chest pain during or after exercise?	☐	☐
	- Do you get tired more quickly than your friends do during exercise?	☐	☐
	- Have you ever had racing of the heart or skipped heartbeats?	☐	☐
	- Have you had high blood pressure or high cholesterol?	☐	☐
	- Have you ever been told you have a heart murmur?	☐	☐
	- Has any family member or relative died of heart problems or of sudden unexpected death before the age of 50?	☐	☐
	- Has any family member been diagnosed with enlarged heart, dilated cardiomyopathy, hypertrophic cardiomyopathy, long QT Syndrome, or another ion channelopathy (Brugada syndrome, etc.), Marfan's Syndrome, or abnormal heart rhythm?	☐	☐
	- Have you had a severe viral infection (i.e., myocarditis or mononucleosis) within the last month?	☐	☐
	- Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
4.	- Have you ever had a head injury or concussion?	☐	☐
	- Have you ever been knocked out, gone unconscious, or lost your memory?	☐	☐
	If yes how many times? _____ Last concussion? _____		
	- How severe was each one? (explain in the box below)		
	- Have you ever had a seizure?	☐	☐
	- Do you have frequent or severe headaches?	☐	☐
	- Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	- Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	- Are you missing any paired organs?	☐	☐
6.	- Are you under a doctor's care for any reason?	☐	☐
7.	- Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills, or use an inhaler?	☐	☐
8.	- Do you have any allergies? i.e., pollen, medicine, food, or stinging insects?	☐	☐
9.	- Have you ever gotten dizzy during or after exercise?	☐	☐
10.	-Do you have any skin problems? i.e., itching, rash, acne, warts fungus, or blisters?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Do you have any problems with your eyes or vision?	☐	☐
13.	- Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	- Do you have asthma?	☐	☐
	- Do you have seasonal allergies that require medical treatment?	☐	☐
14.	-Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? i.e., knee brace, neck roll, foot orthotics, retainer, hearing aid	☐	☐
15.	- Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	- Have you ever broken or fractured a bone or dislocated a joint?	☐	☐
	- Have you had any problem with pain or swelling in muscles, tendons, bones, or joints? If yes check the box below and explain:	☐	☐

☐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?	☐	☐
17.	- Do you feel stressed out?	☐	☐
18.	- Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

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? _____
- Consent to give student skin cancer informational material? ☐ ☐

MALES ONLY

20.	- Do you have two testicles?	☐	☐
	- Do you have testicular masses or swelling?	☐	☐
	- Consent to give student testicular and skin cancer informational material?	☐	☐

An individual answering yes to any question relating to a possible cardiovascular health issue (question 3 above), should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

Explain any yes answers below (use another sheet if needed)

_____
_____
_____
_____

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 illness, 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 injury or illness. ● Any yes answer to questions 1, 2,3,4,5, or 6 requires 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, OR CONTEST BEFORE, DURING, OR AFTER SCHOOL.

For school use only, This Medical History Form was reviewed by:

School Official Name _____

Date _____

Signature_____

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

STUDENT SIGNATURE X _____

PARENT/GUARDIAN SIGNATURE X _____ **DATE** _____

Physical Examination

PSJA STUDENT ID NUMBER _____

Student's Name _____ Sex _____ Age _____ Date of Birth _____/_____/_____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____ (_____/_____; _____/_____)
Brachial blood pressure while sitting (space provided for re-check if needed)

Vision: Right 20 /_____ Left 20 / _____ Corrected: ☐ YES ☐ NO Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this physical examination form must be completed prior to junior high athletic participation and again prior to the first and third years of high school athletic participation. It must be completed if there are any YES answers to specific questions on the medical history form on the reverse side.

PSJA ISD DISTRICT POLICY REQUIRES AN ANNUAL PHYSICAL EXAM

MEDICAL	NORMAL	ABNORMAL FINDING	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 pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectusexcavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

****Initials required for a station-based examination only**

CLEARANCE:

☐Cleared with 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 the 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.

NAME _____ *Date of Examination* _____

ADDRESS _____ *Phone Number* _____

SIGNATURE OF PERSON PERFORMING THE EXAM _____

Must be completed before a student participates in any practice, before, during, or after school, (both in-season and off-season) or games/matches