Medical History (Revised 2020) Clear Form PSJA STUDENT ID NUMBER _____

This Medical History Form must be completed annually by parent (or guardian) and student, for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Students' Name (print) _____ Sex _____ Age _____ Date of Birth _____/_____/_____ Grade _____ School _____

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

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

In case of an emergency contact: Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain YES answers in the box below. Circle questions that you do not know the answer to.

	YES	NO
1. Have you had an illness or injury since your last check up or physical?	☐	☐
2. Have you been hospitalized in the past year?	☐	☐
Have you ever had surgery?	☐	☐
Heart/Cardiac		
3. Have you ever had 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 your heart or skipped heartbeats?	☐	☐
Have you ever 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 sudden unexplained death before the age of 50?	☐	☐
Has any family member ever 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?	☐	☐
Have you ever had a severe viral infection, such as myocarditis or mononucleosis, in the last month?	☐	☐
Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
Neurological		
4. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost memory?	☐	☐
If yes how many times? _____		
When was your last concussion? _____		
How severe was each one? _____		
_____		
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?	☐	☐
General Medical		
5. Are you missing any paired organs?	☐	☐
6. Are you currently under a doctor's care?	☐	☐
7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills?	☐	☐
8. Do you have any allergies? (pollen, medicine, food, stinging insects)	☐	☐
9. Have you ever gotten dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems? (Itching, rashes, acne, warts, fungus, or blisters)	☐	☐
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐
13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you have asthma?	☐	☐
Do you use an inhaler?	☐	☐
Do you have any allergies that require medical treatment?	☐	☐
14. Have you ever been diagnosed with or treated for sickle cell trait or disease?	☐	☐

	YES	NO
Bones & Joints		
15. Do you use any special protective or corrective equipment or devices that are not normally used for your activity or position? (EX, knee brace, special neck roll, foot orthotics, retainer for teeth, hearing aid, insulin pump)	☐	☐
16. Have you ever had a sprain, strain, or swelling after an injury?	☐	☐
Have you ever broken/fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If YES check appropriate box and explain below:

☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder
☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand
☐ Finger ☐ Foot ☐ Hip ☐ Thigh ☐ Knee
☐ Shin/Calf ☐ Ankle

Mental Health		
17. Do you want to weigh either more/less than you do now?	☐	☐
18. Do you feel stressed out?	☐	☐
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 another? _____		
How many periods have you had in the last year? _____		
What was the longest time between periods next year? _____		
Males Only		
20. Do you have 2 testicles?	☐	☐
21. Do you have any testicular, swelling, lumps, or masses?	☐	☐

Electrocardiogram (ECG)

An electrocardiogram (ECG) is **NOT** required. I have read and understand the information about cardiac screening in the UIL Sudden Cardiac Arrest Awareness Form. The PSJA ISD Health Services Department offers ECG screens for a $10.00 fee. I understand it is the responsibility of the family to pay for the ECG.

☐ YES – I would like to obtain an ECG for my student for additional cardiac screening

☐ NO – I decline an ECG for my student

Please explain any YES answers in the box below. 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, nurse practitioner, or chiropractor is required before any participation in UIL practices, games, or matches.

- 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/injury should occur that may limit this student's participation, I agree to notify school authorities of the injury/ illness.

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 _____

To be completed by healthcare provider licensed to practice in the United States. 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 a new physical for each school year.**

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

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

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

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 - Forward Bend Test			
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