



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

1. - Have you had a medical illness or injury since your last check up or sports physical? YES NO
2. - Have you ever been hospitalized overnight in the last year? YES NO
3. - Have you ever had surgery? YES NO
4. - Have you ever had prior testing for the heart ordered by a physician? YES NO
5. - Have you ever passed out during or after exercise? YES NO
6. - Have you ever had chest pain during or after exercise? YES NO
7. - Do you get tired more quickly than your friends do during exercise? YES NO
8. - Have you ever had racing of the heart or skipped heartbeats? YES NO
9. - Have you had high blood pressure or high cholesterol? YES NO
10. - Have you ever been told you have a heart murmur? YES NO
11. - Has any family member or relative died of heart problems or of sudden unexpected death before the age of 50? YES NO
12. - 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? YES NO
13. - Have you ever gotten unexpectedly short of breath with exercise? YES NO
14. - Do you have asthma? YES NO
15. - Do you have seasonal allergies that require medical treatment? YES NO
16. - 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 YES NO
17. - Have you ever had a sprain, strain, or swelling after injury? YES NO
18. - Have you ever broken or fractured a bone or dislocated a joint? YES NO
19. - Have you had any problem with pain or swelling in muscles, tendons, bones, or joints? If yes check the box below and explain:
20. - Do you want to weigh more or less than you do now? YES NO
21. - Do you feel stressed out? YES NO
22. - Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? YES NO
23. FEMALES ONLY
24. - When was your first menstrual period?
25. - When was your most recent menstrual period?
26. - How much time do you usually have from the start of one period to the start of another?
27. - How many periods have you had in the last year?
28. - What was the longest time between periods in the last year?
29. - Consent to give student skin cancer informational material? YES NO
30. MALES ONLY
31. - Do you have two testicles? YES NO
32. - Do you have testicular masses or swelling? YES NO
33. - Consent to give student testicular and skin cancer informational material? YES NO

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 - 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