

**CISD requires an annual physical exam for any student participating in any activity listed on page 2 of this document.**

**\*\*CISD will not accept physicals or completed paperwork dated prior to April 15, 2019\*\***

Student's Name \_\_\_\_\_

Primary Sport \_\_\_\_\_

ID Number \_\_\_\_\_

Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_

**STUDENT – PARENT/GUARDIAN SECTION**

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. 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.

Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to. 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.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. Have you had a medical illness or injury since your last check up or sports physical? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed out during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a head injury or concussion? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____ When was the last concussion? _____  |                          |                          |
| How severe was each one? (Explain) _____   |                          |                          |
| Have you ever had a seizure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you missing any paired organs? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you under a doctor's care? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. 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"/> |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever become ill from exercising in the heat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had any problems with your eyes or vision? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever gotten unexpectedly short of breath with exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. 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"/> |
| 15. Have you ever had a sprain, strain, or swelling after injury? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below.  |                          |                          |
| <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee |                          |                          |
| <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot                  |                          |                          |
| 16. Do you want to weigh more or less than you do now? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you feel stressed out? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**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? \_\_\_\_\_

**Males Only**

20. Do you have two testicles? \_\_\_\_\_  
 21. Do you have testicular swelling or masses \_\_\_\_\_

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physicians assistant, chiropractor, or nurse practitioner.

Explain "yes" answers here (use Notes page, if necessary): \_\_\_\_\_

**MEDICAL EXAMINER SECTION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_

BP (brachial blood pressure while sitting): \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_\_ / \_\_\_\_\_ : \_\_\_\_\_ / \_\_\_\_\_)

Vision: R - 20 / \_\_\_\_\_ L - 20 / \_\_\_\_\_ Corrected: Y N

Pupils: Equal/Unequal %Body Fat (optional): \_\_\_\_\_

| Medical  | Normal | Abnormal Findings | Initials* |
|--|--------|-------------------|-----------|
| Appearance   |        |                   |           |
| Eyes/Ears  |        |                   |           |
| Nose/Throat  |        |                   |           |
| Lymph Nodes  |        |                   |           |
| Heart - Auscultation   |        |                   |           |
| Supine position  |        |                   |           |
| Heart - Auscultation   |        |                   |           |
| Standing position  |        |                   |           |
| Heart - Lower  |        |                   |           |
| Extremity Pulses   |        |                   |           |
| Pulses   |        |                   |           |
| Lungs  |        |                   |           |
| Abdomen  |        |                   |           |
| Genitalia (males only)   |        |                   |           |
| Skin   |        |                   |           |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) |        |                   |           |

**Musculoskeletal**

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

**CLEARANCE** \* Station-based examination only

- 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, 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.

Date of Examination: \_\_\_\_\_

Name (print/type): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

This form and packet, in its entirety, must be on file before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches or performances/competitions.

**For school use only**

**This medical history form was reviewed by:**

Printed name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_