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.*

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2. Have you been hospitalized overnight in the past 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 your 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 age 50?	☐	☐
Has any family member 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 had a severe viral infection *(for example, myocarditis or mononucleosis)* within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
If yes, how many times? _____ *When was the last concussion?* _____		
How severe was each one? *(Explain)* _____		
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?	☐	☐
7. Are you currently taking any prescription or non-prescription *(over-the-counter)* medication or pills or using an inhaler?	☐	☐
8. Do you have any allergies *(for example, to pollen, medicine, food, or stinging insects)*?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems *(for example, 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 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 *(for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)*?	☐	☐
15. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or 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* ☐ *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? _____

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 escavatum, joint hypermobility, scoliosis)*			
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, 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 _____