

**PREPARTICIPATION PHYSICAL EVALUATION - MEDICAL HISTORY**

REVISED 4-20-02

This **MEDICAL HISTORY FORM** must be completed immediately by parent (or guardian) and student in order for that 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's Name: \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

*In case of emergency, contact:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Explain "Yes" answers below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 7, 11, or 17 requires a physical exam using the Preparticipation Physical Evaluation Form on the reverse side.**

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had surgery in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____ When was the last concussion? _____ How severe was each one? (Explain below) _____ Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had numbness or tingling in your arms, hands, legs, or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you cough, wheeze, or have trouble breathing during or after activity? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>10. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. 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"/> Yes <input type="checkbox"/> No</p> <p>13. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below.</p> <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>14. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____</p> <p>17. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Females Only</b></p> <p>18. 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? _____</p>	<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
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**Explain "Yes" answers here: (A "yes" on questions 1, 2, 7, 11 or 17 requires a further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner 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 high 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 sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, 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 illness or injury.

To the Parent:  Baseball  Football  Softball  Tennis  Wrestling

Check any activity in which this student is allowed to participate.  Basketball  Golf  Swimming & Diving  Track & Field

Cross Country  Soccer  Team Tennis  Volleyball

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_