

# Physician's and Parents' Certificate for Jr. High & High School Athletics

University Interscholastic League and The Flour Bluff Independent School District

**Attention:** *This form must be signed by both the student and the parent/guardian and be on file BEFORE the student may participate in any practice session, scrimmage or game. This form may not be altered.*

## Emergency Health and Medical Telephone Numbers

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Last First Middle Initial

Birth Date: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female Sport: \_\_\_\_\_

### Head of Household/Guardian

### Spouse

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**For Emergency Use If Parents Cannot be located. Contacts must be aware of this agreement.**

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

4. Hospital: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

An Athletic Trainer, who is licensed by the state of Texas and designated by the Flour Bluff ISD Board policy, is hereby given my consent to administer non-prescription medication to my child. Further consent is hereby given to administer prescription medication to my child when prescribed by a physician.

**For Football Parents and Students:** Warnings: No helmet can prevent all head or neck injuries a player might receive while participating in football. Do not use the helmet to butt, ram or spear an opposing player. This is in violation of the football rules and can result in severe head and neck injuries, paralysis or death to yourself or your opponent.

### **Insurance Information School Year 2007-2008**

Flour Bluff ISD carries a SUPPLEMENTAL insurance policy covering students who participate in sports, band, and all other extracurricular activities. Parents may choose to purchase a voluntary 24 hour coverage policy from the District's supplemental insurance carrier. The information packet will be made available at all buildings and campuses. For further information contact the District's Risk Manager at 361-694-9730.

## PRE-PARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

This MEDICAL HISTORY FORM must be completed *annually* by a 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: \_\_\_\_\_ 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 in the box below. Circle questions you do not know the answers to. Any YES answer to questions 1,2,5,7,11 or 16 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 / 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. 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"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?   | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?   | <input type="checkbox"/> <input type="checkbox"/> |
| Have you ever been dizzy 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 ever 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 sudden unexpected death before age 50?  | <input type="checkbox"/> <input type="checkbox"/> |
| Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, 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"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?  | <input type="checkbox"/> <input type="checkbox"/> |
| 7. 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 below)   |   |
| 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"/> |
| 8. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Have you gotten unexpectedly short of breath with exercise?  | <input type="checkbox"/> <input type="checkbox"/> |
| Do you cough, wheeze, or have trouble breathing during or after activity?   | <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"/> |

Yes / No

- 10. Have you had any problems with your eyes or vision?
- 11. Are you missing any paired organs?
- 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)?
- 13. 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 the appropriate box(es) and explain below.*  
 Head    Elbow    Hip    Neck    Forearm    Thigh  
 Back    Wrist    Knee    Chest    Hand    Shin/Calf  
 Finger    Ankle    Foot    Shoulder    Upper Arm
- 14. Do you want to weigh more or less than you do now?    
 Do you lose weight regularly to meet requirements for your sport?
- 15. Do you feel stressed out?
- 16. Are you currently under a doctor's care?

**Females Only:**

- 17. 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? \_\_\_\_\_

**An Individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions five above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by the physician, physician assistant, chiropractor, or nurse practitioner. Explain "YES" answers in the box below.**

<b>**EXPLAIN "YES" ANSWERS IN THE BOX BELOW(attach another sheet if necessary):</b>

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, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the 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 each such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL.**

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

**PRE-PARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION**

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_)

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

This PHYSICAL EXAMINATION FORM **must** be completed annually. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side.

MEDICAL	NORMAL	ABNORMAL FINDINGS	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			
<b>MUSCULOSKELETAL</b>			
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.*

Name: (print/type): \_\_\_\_\_ Date of Examination: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_

**Must be completed before a student participates in any practice, during or after school. (both in-season and out-of-season) or games/matches.**

