

COMAL ISD PHYSICAL FORM 2020-21

Student's Name _____

Primary Sport _____

ID Number _____

School/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 activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event. If, between this date and the beginning of participation, 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.

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? | <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 activities 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 your last concussion? _____ | | |
| How severe was each one? (Explain on the back of this page) | | |
| 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"/> |
| Does this allergy require an EpiPen? | <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 activities 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 electrocardiogram (ECG) is **not required**. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

Explain all "yes" answers on the back of this page.

For school use only

This medical history form was reviewed by:

Printed 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 responses could subject the student in question to penalties determined by the UIL.

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

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 <small>(brachiodactylic pectus excavatum, joint hypermobility, scoliosis)</small>			
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, 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.