

Dear Middle School Parents and Athletes,

I am so proud of the athletic program and how much it has grown in the middle school. We have teams competing in every season of the school year with boys' and girls' cross country, girls' volleyball, boys' and girls' basketball, and boys' and girls' track and field teams. This past school year, we were fortunate enough to have fourth grade athletes compete in the track and field season. We are involved in both the Metropolitan Private School League and the Parochial League. All of the teams are representing Oakhill well with their great character, sportsmanship and effort. The middle school athletic program has become a serious program competing to win tournaments and honor our school. As this program grows, practices become more and more strenuous and the athletes work hard for what they want. As our athletes work harder, train more and compete more, Nurse Cathy and I want to make sure our athletes are safe.

Together, Nurse Cathy and I have spoken with other private schools and sports leagues to see what they require regarding athlete health background surveys. Currently, the leagues that we participate in do not require physicals. However, as our students graduate from Oakhill and move on to high school, you will find that MSHAA (Missouri State High School Activities Association), the high school sports league, requires that each school have a sports and health physical on file that is signed by each athlete's doctor. This file enables Coaches to know of any pre-existing health concerns and to have emergency contact information readily available.

Through our research, Nurse Cathy and I have created a new Oakhill Middle School Athlete Physical form. Any student who plans to participate in any school sports team is now required to have this physical filled out and signed by their doctor. The physical form must be turned in to Coach Speer prior to any athletic practice or competition. No information will be released; it will be kept on file only to aid in an emergency situation. We are proud of our athletes and want to make sure we keep everyone safe.

Thank you for your support with the athletics program!

Sincerely,

Coach Speer and Nurse Cathy

## PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

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.

Student's Name: (print) \_\_\_\_\_ 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 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.**

- |   |   |                                    |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |                               |  |
|---|---|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|-------------------------------|--|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>2. Have you been hospitalized overnight in the past year? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever had surgery? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>3. Have you ever passed out during or after exercise? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever had chest pain during or after exercise? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Do you get tired more quickly than your friends do during exercise? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever had racing of your heart or skipped heartbeats? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you had high blood pressure or high cholesterol? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever been told you have a heart murmur? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         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? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Has a physician ever denied or restricted your participation in sports for any heart problems? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>4. Have you ever had a head injury or concussion? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever been knocked out, become unconscious, or lost your memory? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         If yes, how many times? _____<br/>         When was the last concussion? _____<br/>         How severe was each one? (Explain below) _____<br/>         Have you ever had a seizure? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Do you have frequent or severe headaches? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever had numbness or tingling in your arms, hands, legs, or feet? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you ever had a stinger, burner, or pinched nerve? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>5. Are you missing any paired organs? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>6. Are you under a doctor's care? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>7. Are you currently taking any prescription or non-prescription (Over-the-counter) medication or pills or using an inhaler? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>8. Do you have any allergies (for example, to pollen, medicine food, or stinging insects)? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>9. Have you ever been dizzy during or after exercise? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>10. Do you have any current skin problems (for example, itching rashes, acne, warts, fungus, or blisters)? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>11. Have you ever become ill from exercising in the heat? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>12. Have you had any problems with your eyes or vision? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> | <p>13. Have you ever gotten unexpectedly short of breath with exercise? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Do you have asthma? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Do you have seasonal allergies that require medical treatment? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>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)? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you broken or fractured any bones or dislocated any joints? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>If yes, check appropriate box and explain below.</p> <table border="0" style="width: 100%;"> <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><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span><br/>         Do you lose weight regularly to meet weight requirements for your sport? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>17. Do you feel stressed out? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p><b>Females Only</b></p> <p>19. When was your first menstrual period? _____<br/>         When was your most recent menstrual period? _____<br/>         How much time do you usually have from the start of one period to the start of another? _____<br/>         How many periods have you had in the last year? _____<br/>         What was the longest time between periods in the last year? _____</p> <p><b>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, physician assistant, chiropractor, or nurse practitioner.</b></p> <p><b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW</b> (attach another sheet if necessary):<br/>         _____<br/>         _____<br/>         _____</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 |  |
| <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   |                                    |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |                               |  |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. The school is not responsible 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 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.

**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: \_\_\_\_\_

**THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

**For School Use Only:**

This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_



**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_,\_\_\_\_\_/\_\_\_\_\_)  
Brachial blood pressure while sitting

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

As a minimum requirement, this **Physical Examination Form** must be completed prior to any athletic participation in any sport once a year. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side.

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS*</b>
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			
Marfan's stigmata (arachnodactyly, pectus joint hypermobility, scoliosis)			

**MUSCULOSKELETAL**

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

**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, before, during or after school, (both in-season and out-of-season) or games/matches.