Sports Physical -- 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 _____
Family 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.***

		Yes or No		If yes please explain
1.	Has a Doctor ever denied or restricted your participation in sports for any reason.	☐	☐	_____
2.	Do you have any ongoing medical conditions? If so, please identify_____	☐	☐	
3.	Have you been hospitalized overnight in the past year?	☐	☐	_____
4.	Have you ever had surgery?	☐	☐	
5.	Have you ever felt dizzy or passed out during or after exercise?	☐	☐	_____
6.	Have you ever had chest pain during or after exercise?	☐	☐	
7.	Have you ever had racing of your heart or skip beats?	☐	☐	_____
8.	Has a physician ever told you that you have any heart problems?	☐	☐	
9.	Have you ever had a seizure?	☐	☐	_____
10.	Do you get tired more quickly than your friends do during exercise?	☐	☐	
11.	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐	_____
12.	Does anyone in your family have a heart condition?	☐	☐	
13.	Have you ever had an injury to a bone, muscle, ligament, or tendon that has caused you to miss practice or a game?	☐	☐	_____
14.	Have you ever had a broken or fractured bone or dislocated joints?	☐	☐	
15.	Have you ever had a stress fracture?	☐	☐	_____
16.	Do you regularly use a brace, orthotics, or other assistive device?	☐	☐	
17.	Do you have a bone, muscle or joint that bothers you?	☐	☐	_____
18.	Do you cough, wheeze or have difficulty breathing or after exercise?	☐	☐	
19.	Have you ever used an inhaler or taken asthma medicine?	☐	☐	_____
20.	Do you have any allergies (for example, to pollen, medicine food, or stinging insects)?	☐	☐	
21.	Do you have groin pain or a bulge or hernia in the groin area?	☐	☐	_____
22.	Have you had Mono within the last month?	☐	☐	
23.	Do you have rashes, pressure sores or other skin problems?	☐	☐	_____
24.	Have you had a herpes or MRSA skin infection?	☐	☐	
25.	Have you ever had a head injury or concussion? If yes, how many times? _____ When was the last concussion? _____	☐	☐	_____
26.	Do you have frequent or severe headaches?	☐	☐	_____
27.	Have you ever had numbness or tingling in your arms, hands legs, or feet?	☐	☐	
28.	Have you ever become ill from exercising in the heat?	☐	☐	_____
29.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐	
30.	Have you had any problems with your eyes or vision?	☐	☐	_____
31.	Do you worry about your weight?	☐	☐	
32.	Are you trying or has any recommended you gain or lose weight?	☐	☐	_____
33.	Do you feel stressed out?	☐	☐	
34.	DO you have any concerns that you would like to discuss with the Doctor?	☐	☐	_____

Females Only

35. 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? _____

It is understood that even though protective equipment may be worn by the athlete, 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 may be given to the student by any physician, athletic trainer, 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 will 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: _____

Oakhill Day School Sports Physical -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ Pulse_____ BP____/____

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.

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			
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.