

Student ID #

# Southside ISD Athletic Department 2020-2021 School Year

05/05/2020

STUDENT NAME:

(Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

AGE \_\_\_\_\_ Date of Birth \_\_\_\_\_ SEX: Male Female

Please Circle School: **Matthey Middle School** **Losoya Middle School**  
Please Circle Grade: **7th (2026)** **8th (2025)**

Please Circle School: **Southside High School**  
Please Circle Grade: **9th (2024)** **10th (2023)** **11th (2022)** **12th (2021)**  
(High School Forms must be renewed yearly)

Parent Mother/Guardian

NAME \_\_\_\_\_ Phone \_\_\_\_\_

Parent Father/Guardian

NAME \_\_\_\_\_ Phone \_\_\_\_\_

Please Circle:
ATHLETICS
BAND
CHEER
FINE ARTS

\*\*Other than Parent /Guardian Emergency Contact

NAME \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Parents/Guardians have the opportunity to purchase Affordable Accident Only Insurance for students. I would like a brochure: YES NO

AIR QUALITY ALERT: Do you have Asthma? Do you carry an inhaler?  
YES NO YES NO

If you are prescribed an inhaler, athlete needs to keep a labeled inhaler accessible with their name during athletic events/practices.

You will be required to have your physician complete an Asthma Action Plan Form.

This form can be obtained from the Athletic Trainer Office, or accessed from the Southside ISD Health Services Site: [www.southsideisd.org](http://www.southsideisd.org)

Please List Medications/Allergies (Please be specific)

## 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 activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event. Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to.

1. Have you had a medical illness or injury since your last check up or physical?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2. Have you been hospitalized overnight in the past year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	12. 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"/>
13. Have you ever had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	14. Has a physician ever denied or restricted your participation in activities for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
15. If yes, how many times? _____			16. How severe was each one? (Explain below)		
17. How severe was your last concussion?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>

1. Have you ever had a stinger, burner, or pinched nerve?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2. 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"/>			
3. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Have you ever had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have seasonal allergies that require medical treatment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>			
13. Have you ever broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>			
14. If yes, check appropriate box and explain below:			15. Head	<input type="checkbox"/>	16. Elbow	<input type="checkbox"/>	17. Hip	<input type="checkbox"/>
			18. Neck	<input type="checkbox"/>	19. Forearm	<input type="checkbox"/>	20. Thigh	<input type="checkbox"/>
			21. Back	<input type="checkbox"/>	22. Wrist	<input type="checkbox"/>	23. Knee	<input type="checkbox"/>
			24. Chest	<input type="checkbox"/>	25. Hand	<input type="checkbox"/>	26. Shin/Calf	<input type="checkbox"/>
			27. Shoulder	<input type="checkbox"/>	28. Finger	<input type="checkbox"/>	29. Ankle	<input type="checkbox"/>
			30. Upper Arm	<input type="checkbox"/>	31. Foot	<input type="checkbox"/>		

ATHLETE MUST COMPLETE UIL FORMS ONLINE: <https://southsideisd.rankonesport.com>



An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardia 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 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Intercollegiate League nor the 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 and any school or hospital representative from any claim by any person on account of said care and treatment of said student. 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.

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: \_\_\_\_\_  
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. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE 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**

05/05/2020

Student's Name \_\_\_\_\_ Student ID # \_\_\_\_\_ 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 junior high participation and again prior to first and third years of high school participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. \* **Local district policy may require an annual physical exam.**

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</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 excavatum, joint hypermobility, scoliosis)			

**MUSCULOSKELETAL**

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