Electronic 2019-2020 TOMBALL ISD PRE-PARTICIPATION ATHLETIC FORM

ALL INFORMATION IS *REQUIRED* **DO NOT LEAVE ANY BLANKS **PRINT LEGIBLY WITH BLUE OR BLACK INK**

Student's Last Name / **Student's First Name** / **Student's Middle Name**

TISD Student ID # **Gender** **Date of Birth** **2019-2020 GRADE** **2019-2020 Campus**

Mark the box next to the sport(s) in which you plan to participate:

Band☐ Baseball☐ Basketball☐ Cheerleading☐ Cross Country☐ Drill Team☐ Football☐ Golf ☐ Manager☐ ROTC☐

Soccer☐ Softball☐ Student Trainer ☐ Swimming & Diving☐ Tennis☐ Track & Field ☐ Volleyball☐ OTHER: _____

Parent/Guardian 1 FULL Name *(include last name)* / **Parent/Guardian 1 – Cell Phone** / **Parent/Guardian 1 – E-MAIL (PRINT)**

Parent/Guardian 2 FULL Name *(include last name)* / **Parent/Guardian 2 – Cell Phone** / **Parent/Guardian 2 – E-MAIL (PRINT)**

Allergies to medication or other (please list):_____

Any medications taken regularly (please list): _____

Any medical concerns that should be noted: _____

Mark the box to indicate Yes or No

Sickle Cell/ Trait: YES☐ NO☐ Diabetes: YES☐ NO☐ Epilepsy/ Seizure Disorder: YES☐ NO☐ Concussions: NO☐ YES☐ Dates: _____

CONSENT TO TREAT

Your signature below gives authorization to the Licensed Athletic Trainers (LAT), associated physicians, coaches/school personnel and other medical professionals to evaluate, care and treat your student as a result of any injury or sickness and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of student.

RELEASE TO RETURN TO PARTICIPATION AFTER ANY MEDICAL CONSULTATION

I understand that any student who seeks medical care from a HealthCare Provider for any injury or illness will not be permitted to return to athletic participation until a signed and dated physician's release has been provided to the License Athletic Trainer (LAT) or designee; regardless of whether they are removed from or have restrictions placed on their ability to participate. Parental authorization or notification cannot be accepted in place of the medical release/note. This includes any and all injury/ illness that may not be school related (club/ off campus).The physician notes should include a diagnosis with any restriction or treatments; these are not "attendance" notes.

MEDICATION PERMIT

Athletic Trainers, Licensed by the State of Texas (LAT) may distribute over-the counter medications in accordance with a standing order from physician with permission from the parent. [See Tomball ISD Board Policy FFAC{LOCAL}]

OTC medications include, but are not limited to: Pain reliever/Fever reducers (Ibuprofen, Acetaminophen, Midol); Gastrointestinal Aids (Pepto-Bismol, Imodium, Tums, Emetrol); Cold/Sinus (Sudafed, Tylenol Cold & Sinus, cough drops); Allergy(Benadryl); Medications and/or Inhalers prescribed by a physician

I, hereby give consent to the athletic trainers employed by Tomball ISD to administer non-prescription, over-the-counter (OTC) medication to my child.
YES☐ NO☐

MEDICAL INFORMATION

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians, school personnel and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Once ALL electronic forms have been submitted (online or paper) **AND** the TISD Pre-Participation Physical Form has been physically turned in and verified by the **License Athletic Trainer (LAT) THEN** the student-athlete will be eligible (CLEARED) to participate in activities including practices before, during & after school (this includes the athletics class period). Contact your Campus LAT with any questions.

X **Parent/Guardian Sign (required):** _____ **Date:** _____

For School Personnel Use Only: **Licensed Athletic Trainer or Jr. High Designee ONLY** **Date/ Sign**

Electronic Forms Submitted: _____ **Pre-Participation Medical History & Physical Form Submitted:**_____

Student's Name: _____ **Gender**_____ **Age**_____ **Date of Birth** _____

STUDENT – PARENT/GUARDIAN SECTION

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent/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. ***Explain all "Yes" answers. 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	NO
1. Have you had a **medical illness or injury** since your last check up or sports physical?		
2. Have you been **hospitalized** overnight in the past year?		
Have you ever had **surgery**?		
3. Have you ever had prior **testing for the heart** ordered by a physician?		
Have you ever **passed out** during or after exercise?		
Have you ever had **chest pain** during or after exercise?		
Do you get tired more quickly than your friends do during exercise?		
Have you ever had **racing of your heart or skipped heartbeats**?		
Have you had **high blood pressure or high cholesterol**?		
Have you ever been told you have a **heart murmur**?		
Has any **family member** or relative died of **heart problems** or of sudden unexpected death **before age 50**? **WHO:**		
Has any **family member** been diagnosed with enlarged heart (dilated cardiomyopathy), Hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? **WHO:**		
Have you had a severe **viral infection** (for example, myocarditis or mononucleosis) within the last month?		
Has a physician ever denied or restricted your participation in sports for any heart problems?		
4. Have you ever had a **head injury or concussion**?		
Have you ever been **knocked out, become unconscious, or lost your memory**?		
If yes, how many **times**? When was the last **concussion**?		
How severe was each one? (Explain)		
Have you ever had a **seizure**?		
Do you have frequent or severe **headaches**?		
Have you ever had **numbness or tingling** in your arms, hands, legs, or feet?		
Have you ever had a stinger, burner, or pinched nerve?		
5. Are you missing any paired organs?		
6. Are you under a doctor's care?		
7. Are you **currently taking any prescription or non-prescription** (over-the-counter) **medication or pills or using an inhaler**?		
8. Do you have any **allergies** (for example, to pollen, medicine, food, or stinging insects)?		
9. Have you ever been **dizzy** during or after exercise?		
10. Do you have any current **skin problems** (for example, itching, rashes, acne, warts, fungus, or blisters)?		
11. Have you ever become ill from exercising in the heat?		
12. Have you had any problems with your **eyes or vision**?		
13. Have you ever gotten unexpectedly short of breath with exercise?		
Do you have asthma?		
Do you have **seasonal allergies** that require medical treatment?		
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)?		
15. 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 appropriate box and explain:		
Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Hand ☐ Shin/Calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Upper Arm ☐ Foot ☐ Chest ☐		
16. Do you want to weigh more or less than you do now?		
Do you lose weight regularly to meet weight requirements for your sport?		
17. Do you feel stressed out?		
18. Have you ever been diagnosed with/or treated for **sickle cell trait or disease**?		
19. ***Females Only:*** 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?		
20. ***Males Only***: Do you have two Testicles?		
21. ***Males Only:*** Do you have any Testicular swelling or masses?		

MEDICAL EXAMINER SECTION

As a minimum requirement this **PHYSICAL EXAMINATION FORM** *must* be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It must be completed if there are "**yes**" answers to specific questions on the student's MEDICAL HISTORY FORM in the left column. ***TISD requires an annual physical exam dated after April 1st for the next school year.**

Height:_____ **Weight:**_____ **Pulse:**_____

BP:_____/_____ (_____/_____:_____/_____)
Brachial Blood Pressure while sitting

Vision: R – 20/_____ **L – 20/**_____ **Corrected: Y N**

Pupils: Equal / Unequal **%Body Fat (optional):**_____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart – Auscultation Standing			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hyper- mobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

** Station-based examination only*

CLEARANCE

O <u>Cleared</u>

O Cleared **<u>after completing evaluation/rehabilitation</u>** for:

_____

O <u>Not cleared</u> 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.

<u>Date of Examination</u>: _____

<u>Stamp or Label:</u>

MD Name:_____

Address:_____

Phone Number:_____

<u>Physician's Signature</u>:_____

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, physicians assistant, chiropractor, or nurse practitioner. EXPLAIN 'YES' ANSWER (attach another sheet if necessary):

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the UIL nor Tomball ISD 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 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 & TISD.

X **Parent/Guardian Sign *(required)*:** _____ **Student Sign *(required)*:** _____ **Date:** _____

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

<u>For School Personnel Use Only</u>: Athletic Trainer or Jr High Coach

Medical History Form was reviewed by Name_____ **Date**_____

HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Please Print in Box

School:_____

Student Name:_____

Confirmation of Understanding of Limited Scope and Purpose of the Extracurricular/Co-Curricular Preparticipation Physical Exams

I, _____, (Print Parent/Legal Guardian Name) am aware that my child/ward, _____ (Print Child's Name), will attend an event providing preparticipation physical exams for student athletes at _____ on _____, ____, 20___ ("the event"). The event is sponsored and provided by Houston Methodist ("Houston Methodist") for the sole purpose of clearing students for participation in extracurricular/co-curricular programs. The screening physical exam will be performed by volunteer health care providers. By signing this form, I am confirming I understand and agree to the following:

- **I consent to the extracurricular/co-curricular physical exam for the above named child;**
- This is **NOT** a comprehensive physical exam and should not take the place of routine medical care. I understand that this is a **screening physical for clearance for participation in extracurricular/co-curricular activities ONLY;**
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- I understand that my child may need additional testing before he or she can be cleared for participation in athletic activities and it is my sole responsibility to obtain such additional testing or medical care. I understand that if it is determined that my child needs additional medical treatment, I will be notified of any such recommendation. I understand that a limited number of non-invasive tests may be available and performed at the event for my convenience. **I consent to any and all additional non-invasive testing as deemed necessary by the screening physician during the event without notification to me prior to the testing;** and
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event. This consent is valid for 180 days and I understand that I may revoke this consent at any time. I understand that the information released may not be protected under the law once it is disclosed and may be subject to redisclosure by the Recipient.

_____

Parent/Guardian's Signature Date

RELEASE FROM LIABILITY AND INDEMNIFICATION

I hereby release, waive, discharge and covenant not to sue Houston Methodist and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the extracurricular/co-curricular Physical Examination Event.

I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in the Release.

_____

Parent/Guardian's Signature Date