

## **PHYSICALS 2009 -2010**

Prospective student athletes and parents:

We are preparing for the 2009 2010 School year and there have been some changes in the requirements for your child to participate.

Starting in the 2009 2010 school year every child participating in Athletics at every grade level must have a physical EVERY YEAR so a YEARLY PHYSICAL. This is a change from our past policy of every other year.

As always this has to be completed BEFORE THE STUDENT ATHLETE CAN PARTICIPATE IN PRACTICE OR GAMES.

We are offering Physicals on the Following dates for \$ 15.

PHYSICALS ARE OFFERED ON THE FOLLOWING DATES FOR \$15 STARTING AROUND 4 PM.

AT CLEBURNE HIGH SCHOOL IN THE GYM AREA ON

May 4<sup>th</sup> and May 6<sup>th</sup>

AT SMITH MIDDLE SCHOOL IN THE GYM AREA ON:

May 11<sup>th</sup>

AT WHEAT MIDDLE SCHOOL IN THE GYM AREA ON:

May 13<sup>th</sup>.

PLEASE TURN IN PAPERWORK TO MS MARTINO IN THE TRAINING ROOM BY AUGUST 3<sup>RD</sup> FOR FOOTBALL, VOLLEYBALL AND CROSS COUNTRY. NO LATER THAN THE 1<sup>ST</sup> DAY OF SCHOOL FOR THE REMAINING SPORTS PLEASE.

If you have questions or concerns please feel free to contact

Kathy Martino 817 202 1692



# CLEBURNE ISD 2009 -2010

## STUDENT ATHLETE EMERGENCY CARD

NAME: \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SEX \_\_\_\_ GRADE: \_\_\_\_  
**Must be full, legal name.** Last, First, Middle

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Athletes Cell Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

1<sup>st</sup> Parent/Guardian Name: \_\_\_\_\_ Relation \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PLACE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ Contact  
1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

2<sup>nd</sup> Parent/Guardian Name: \_\_\_\_\_ Relation: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PLACE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ Contact  
1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

If Parents can not be reached, Notify: \_\_\_\_\_ RELATION: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Contact  
1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>

FAMILY PHYSICIAN: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

PREFERED HOSPITAL: \_\_\_\_\_

Hospitalization insurance company: \_\_\_\_\_ Group # or individual # \_\_\_\_\_

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ School I.D. #: \_\_\_\_\_

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, ad travel with the coach or other representative of the school on any trips. If, in the judgement 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 to said student by any physician, trainer, nurse, hospital, or school representative; 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 said student.

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SPORTS TO BE PARTICIPATING IN: \_\_\_\_\_  
CLEBURNE ISD

# DISTRICT 16-4A

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Mr. Phillip Young  
Athletic Director  
Cleburne High School  
1501 Harlin Drive  
Cleburne, Texas 76033

Telephone (817)202-1250  
Fax (817)202-1472

2009-2010

To: CISD Parents  
From: Phillip Young  
Re: Insurance Coverage

Dear Parents:

Cleburne ISD has contracted an insurance policy for the 2009-2010 school year.

Under this insurance policy, your child is covered through an athletic "blanket coverage" which covers any and all practices, games, and athletic trips. This policy is a secondary coverage, which is supplemental to your primary coverage. However, if your child is not covered by a current health care insurance policy, the blanket coverage will become the primary coverage.

It is important to note that our athletic "blanket" policy is supplemental. Therefore, the schedule of benefits is designated to be supplemental to a primary policy which in turns means a limited payout towards the health care bill.

Parents, to provide the best care possible for your child in case of injury; we need to have adequate records of your child's primary insurance provider. If you will, please complete the pertinent information below, regarding your personal health plan for your child.

Please indicate whether or not your child is currently covered by a health care plan purchased for your family.

\_\_\_\_\_ YES, WE HAVE HEALTH INSURANCE. \_\_\_\_\_ NO, WE HAVE NO HEALTH INSURANCE.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT FULL (LEGAL) STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

If yes, to aid the athletic department in providing adequate records for your child, please indicate the type of health care policy you have purchased.

I HAVE A "PRIMARY" HEALTH CARE POLICY WITH: \_\_\_\_\_

THE POLICY NUMBER OR INDIVIDUAL NUMBER IS: \_\_\_\_\_

Thank you for your cooperation, please sign and return through your child back to the CHS Athletic Department as soon as possible.

If you have any additional questions, please contact our athletic trainer at phone # (817)202-1690

**CLEBURNE INDEPENDENT SCHOOL DISTRICT  
DRUG/ALCOHOL SCREENING TEST**

**STUDENT/PARENT CONSENT**

I, \_\_\_\_\_ as a parent/guardian of \_\_\_\_\_, a minor student enrolled in Cleburne High School and participating in \_\_\_\_\_ represent that I have the authority to consent to drug/alcohol testing of my child.

I understand the Cleburne Independent School District's ("CISD") policy regarding substance abuse and participation in CISD sponsored extracurricular activities. I understand that it is the practice of the CISD to conduct drug/alcohol tests for the purpose of carrying out this policy and before allowing students to participate in extracurricular activities.

I understand that my child cannot be compelled to give a urine sample. **I UNDERSTAND THAT IF HE/SHE GIVES A URINE SAMPLE IT WILL BE TESTED FOR DRUGS AND/OR ALCOHOL.** I understand that the giving of a urine sample, when requested by the CISD is a condition of my child's continued participation in extracurricular activities. I understand that If a test of my child's urine sample reveals an unexplained presence of a drug or alcohol, The CISD may take disciplinary action against him/her up to and including termination from participation in extracurricular activities. An exception will be made for use of legally prescribed medications taken under the direct supervision of a physician. **BASED ON MY UNDERSTANDING OF THE ABOVE, I HEREBY AUTHERIZE '24/7 MOBILE DRUG AND ALCOHOL TESTING' TO COLLECTA URINE SAMPLE FROM MY CHILD FOR THE PURPOSE OF TESTING FOR THE PRESENCE OF DRUGS AND/OR ALCOHOL.**

I further authorize the officers, employees, and agents of '24/7 MOBILE DRUG AND ALCOHOL TESTING' and CISD to communicate my Child's drug/alcohol test results both orally and in writing, and to communicate such test results to the CISD Principal and Athletic Director. I also authorize the officers, employees, and agents of '24/7 MOBILE DRUG AND ALCOHOL TESTING' and CISD to have continued access to my child's urine sample/test results for the purpose of any further analysis or study that may be necessary, and require the results be communicated to me prior to any CISD administrative proceedings or disciplinary actions. I understand that this information will not become part of my child's medical record. I also understand that no physician/Patient relationship is established by the collection of this urine sample by 24/7 MOBILE DRUG AND ALCOHOL TESTING', and that no privilege of confidentiality will be attach to these test results.

**I HEREBY RELEASE AND HOLD HARMLESS 24/7 MOBILE DRUG AND ALCOHOL TESTING', ITS TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, REPRESENTATIVES, AND MEDICAL STAFF MEMBERSFROM ANY AND ALL LIABILITY, CLAIMS, DAMAGES AND COSTS THAT MAY ARISE AS A RESULT OF ANY ACTION TAKEN OR UNFAVORABLE OUTCOME THAT OCCURS AS A RESULT OF THIS DRUG/ALCOHOL TEST.**

**My child has taken the following prescribed and/or over the counter drugs or substances within the last two weeks:**

\_\_\_\_\_

\_\_\_\_\_

**This is a legal consent and release of liability form. Please read it carefully  
and be sure your questions have been answered before signing.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Full Name (Parent/Guardian)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Student ID

\_\_\_\_\_  
Printed Full Legal Name of Student (Last, First Middle)

\_\_\_\_\_  
Grade for 2009-2010 year



University Interscholastic League



Parent and Student Agreement/Acknowledgement Form
Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
• Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
• Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
• Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.texas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.texas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RULES**

*Attention School Authorities:* This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

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

Current School \_\_\_\_\_

**Parent or Guardian's Permit**

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; 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 said student.

**I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.**

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

- |   |  |                                   |  |  |                                    |
|---|--|-----------------------------------|--|--|------------------------------------|
| <b>To the Parent:</b>                     | <input type="checkbox"/> Baseball      | <input type="checkbox"/> Football | <input type="checkbox"/> Softball          | <input type="checkbox"/> Tennis        | <input type="checkbox"/> Wrestling |
| <b>Check any activity in which this</b>   | <input type="checkbox"/> Basketball    | <input type="checkbox"/> Golf     | <input type="checkbox"/> Swimming & Diving | <input type="checkbox"/> Track & Field |                                    |
| <b>student is allowed to participate.</b> | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Soccer   | <input type="checkbox"/> Team Tennis       | <input type="checkbox"/> Volleyball    |                                    |

Date \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_

Street address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home area code and telephone \_\_\_\_\_

Business telephone \_\_\_\_\_

***The student's signature is required on the reverse side of this form.***

## GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: school coaches may hold one 6-day camp in their school district for incoming 7th, 8th and 9th grade students),
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, football, soccer, softball, or volleyball.
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

## GENERAL ELIGIBILITY RULES

According to UIL standards, students are eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See 504 handicapped exception.)
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time day students in a participant high school.
- initially enrolled in the ninth grade not more than four calendar years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the *Constitution and Contest Rules*).
- have observed all provisions of the Awards Rule.
- have not represented a college in a contest.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not allow their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.
- **I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.**

I have read the regulations cited above and agree to follow the rules.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of student

**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

REVISED 1-6-09

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**

	Yes	No		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"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<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 sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<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 broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
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"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many _____ When was the last concussion? _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<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"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
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"/>	What was the longest time between periods in the last year? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<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>		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</b>		
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"/>	_____		

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic 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 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: \_\_\_\_\_ Date: \_\_\_\_\_

**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 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 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)			
<b>MUSCULOSKELETAL</b>			
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 games/matches.