Electronic 2017-2018 KLEIN 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

KISD Student ID # Gender Age Date of Birth 2017-18 GRADE

17-18 School:_____ List the sport(s) in which you plan to participate: _____

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: _____

List all Surgeries: _____

Sickle Cell/ Trait: YES / NO Diabetes: YES / NO Epilepsy/ Seizure Disorder: YES / NO

Diagnosed Concussions: NO / YES- Dates: _____ Baseline ImPACT Testing: NO / YES- Date(s): _____

CONSENT & RELEASE TO RETURN TO PARTICIPATION AFTER ANY MEDICAL CONSULTATIONS

Athletes who seek medical attention from a HealthCare Provider for any injury or illness, regardless of whether they are removed from or have restrictions placed on their ability to participate, CANNOT return to athletic participation until a signed and dated physician's release has been provided to the Athletic Trainer (AT) or designee. Parental authorization or notification will NOT 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).

Any Athlete that see any Medical Professional for any reason, must have a note from that Medical Professional BEFORE being able to resume Participation– NO EXCEPTIONS!** MD notes should include a Diagnosis including any restrictions- these notes are not "attendance" notes.

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-ATHLETE.

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

Once ALL electronic forms have been sumitted (online or paper) AND the KISD Pre-Participation Physical Form has been physically turned in and verified by the High School Athletic Trainer (AT)/ Intermediate Head Coach, THEN the student-athlete will be eligible (Cleared) to participate in athletics events including practices before, during & after school (this includes the athletics class period).
Contact your Campus AT with any questions.

For School Personnel Use Only: Athletic Trainer or Intermediate Coach ONLY Page 1 of 2

Electronic Forms Submitted (date):_____ Verified By (Signature) / Date: _____

Pre-Participation Medical History & Physical Form Submitted(date):_____ Verified By (Signature) / Date: _____

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?	O	O
2. Have you been **hospitalized** overnight in the past year?	O	O
Have you ever had **surgery**?	O	O
3. Have you ever had prior **testing for the heart** ordered by a physician?	O	O
Have you ever **passed out** during or after exercise?	O	O
Have you ever had **chest pain** during or after exercise?	O	O
Do you get tired more quickly than your friends do during exercise?	O	O
Have you ever had **racing of your heart or skipped heartbeats**?	O	O
Have you had **high blood pressure or high cholesterol**?	O	O
Have you ever been told you have a **heart murmur**?	O	O
Has any **family member** or relative died of **heart problems** or of sudden unexpected death **before age 50**? WHO:	O	O
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:	O	O
Have you had a severe **viral infection** (for example, myocarditis or mononucleosis) within the last month?	O	O
Has a physician ever denied or restricted your participation in sports for any heart problems?	O	O
4. Have you ever had a **head injury or concussion**?	O	O
Have you ever been **knocked out, become unconscious, or lost your memory**?	O	O
If yes, how many **times**? _____ When was the last **concussion**? _____		
How severe was each one? (Explain)_____		
Have you ever had a **seizure**?	O	O
Do you have frequent or severe **headaches**?	O	O
Have you ever had **numbness or tingling** in your arms, hands, legs, or feet?	O	O
Have you ever had a stinger, burner, or pinched nerve?	O	O
5. Are you missing any paired organs?	O	O
6. Are you under a doctor's care?	O	O
7. Are you **currently taking any prescription or non-prescription** (over-the-counter) **medication or pills or using an inhaler**?	O	O
8. Do you have any **allergies** (for example, to pollen, medicine, food, or stinging insects)?	O	O
9. Have you ever been **dizzy** during or after exercise?	O	O
10. Do you have any current **skin problems** (for example, itching, rashes, acne, warts, fungus, or blisters)?	O	O
11. Have you ever become ill from exercising in the heat?	O	O
12. Have you had any problems with your **eyes or vision**?	O	O
13. Have you ever gotten unexpectedly short of breath with exercise?	O	O
Do you have **asthma**?	O	O
Do you have **seasonal allergies** that require medical treatment?	O	O
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)?	O	O
15. Have you ever had a **sprain, strain, or swelling after injury**?	O	O
Have you broken or fractured any bones or dislocated any joints?	O	O
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below	O	O
O Head O Elbow O Hip O Neck O Forearm O Thigh O Back O Wrist O Knee O Hand O Shin/Calf O Shoulder O Finger O Ankle O Upper Arm O Foot O Chest		
16. Do you want to weigh more or less than you do now?	O	O
Do you lose weight regularly to meet weight requirements for your sport?	O	O
17. Do you feel stressed out?	O	O
18. Have you ever been diagnosed with/or treated for **sickle cell trait or disease**?	O	O

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?

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):

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. *KISD requires an annual physical exam.

Height:_____ Weight:_____ Pulse:_____

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

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

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

MEDICAL	Normal	Abnormal Findings	Initials*
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			

CLEARANCE ** Station-based examination only*

O Cleared

O Cleared **after completing evaluation/rehabilitation** for:

_____

O Not cleared 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.

Date of Examination: _____

Stamp or Label:

MD Name:_____

Address:_____

Phone Number:_____

Physician's Signature:_____

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 Klein 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 & KISD.

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.

For School Personnel Use Only: Athletic Trainer or Intermediate Head Coach
Medical History Form was reviewed by Name_____ Date_____