

**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.

**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

2017

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.

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No                  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"/> Yes <input type="checkbox"/> No                  Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, how many times? _____                  When was your last concussion? _____                  How severe was each one? (Explain below) _____                  Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, check appropriate box and explain below:</p> <table border="0" style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weight more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females Only</i></p> <p>19. 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? _____</p> <p><i>Males Only</i></p> <p>20. Do you have two testicles? _____</p> <p>21. Do you have any testicular swelling or masses? _____</p>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
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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.

**\*\*EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (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 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: \_\_\_\_\_

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 OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

*For School Use Only:*  
 This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

ATH TRAINER: \_\_\_\_\_ CLEARED: \_\_\_\_\_ DATE: \_\_\_\_\_ RETURN: \_\_\_\_\_ NEW: \_\_\_\_\_

**This section to be completed and signed by the ATHLETIC TRAINER Only.**

**YISD – ATHLETIC EMERGENCY FORM**

**(Please COMPLETE ALL OF THE INFORMATION COMPLETELY AND CLEARLY)**

NAME: \_\_\_\_\_ GRADUATION YEAR: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ STUDENT I.D.#: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ATHLETES GENDER: (CIRCLE)                      MALE      FEMALE

SPORTS: (CIRCLE ALL THAT APPLY) Baseball, Basketball, Cheerleading, Cross Country/Track, Football, Golf, Gymnastics, Saltatrix,  
Soccer, Softball, Swimming, Tennis, Trooperettes, Volleyball, Wrestling

**In case of Emergency Notify (OTHER THAN PARENT):**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Known allergies: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Medical Problems: (List all medical problems- Including ASTHMA, DIABETES, HEART CONDITIONS, etc.)

While competing do you wear (circle one):                      Glasses                      Contacts: soft/hard

Welcome to the Athletics Parent Portal.

**Directions for filling out online athletic paperwork packets. Go to website:**

**<https://ysletaisd.rankonesport.com>**

You must click on electronic forms there are 7 forms that must be filled out and electronically signed online.

- To access the online forms hold your cursor over the "Electronic Participation Forms" tab. You will get a drop down list of the forms.

- Click on the form name and fill out the information requested. (you must have your students ID number available as it is required on each form)

- To sign the document click inside the signature box and hold your mouse down, this will allow you to create an "Electronic Signature". If you make a mistake and need to start over click on the refresh icon next to the signature box.

- You will also need to print a physical form from the link at the top of the page for your doctor of choice to fill out. Physicals are good from June 1st of current school year through May 31st the end of the school.

- If you need help filling out any forms please contact your coach or school's athletic trainer for assistance.

- Parents/Guardian's and students will need to fill out these forms together as both signatures are required.

- Once you have filled out all of the information on each page, you will have the opportunity to print the document.

- The hard copy of your physical form must be turned in to your student's campus athletic trainers. All other forms will be submitted electronically.

- You will be given clearance to begin participation from your campus Athletic Training Department.

- Your Coach will have access to let you know when all forms are turned in as you will turn green in the rankone website.

**Bel Air High School**

**Joe Messinger LATC 915-487-4953**

**Kelly Powers 419-705-0113**

**Stadium Training room (AM)915-434-2082**

**Field House Training Room (PM after 4) 434-2089**

**Eastwood HighSchool**

**Scott Smelser LAT 915-204-2187**

**Jessica Farris LATC 915-355-0608**

**Parkland High School & Parkland Middle School Nancy C. Vanley, LAT 915-346-1599**