

## Eanes ISD Pre-Participation Physical Evaluation Form

Last Name	First Name	MI	Student ID	Grade	Date of Birth	Sex	Sports (List All Participating In)
Street Address (No P.O. Boxes)				City Zip			Home Phone
Female Guardian's Name		Employer		Cell Phone		Work Phone	Relationship to Student
Male Guardian's Name		Employer		Cell Phone		Work Phone	Relationship to Student
Secondary Emergency Contact Name				Cell Phone		Home Phone	Relationship to Student

**EANES ISD POLICY REQUIRES THAT EACH ATHLETE HAVE ANNUAL PHYSICAL DATED AFTER APRIL 30, 2019**

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

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician? • What age? _____ • What was the diagnosis? _____ • Have you ever passed out during or after exercise? • Do you get tired more quickly than your friends 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? • Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy) hypertrophic cardiomyopathy, long QT syndrome, or abnormal heart rhythm)? • Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the last month? • Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever been unexpectedly short of breath with exercise? Have you ever been diagnosed with asthma? Within the past year, have you experienced an asthma attack? Are you prescribed an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
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 in Responses section • 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?	<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 (ex: knee brace, special neck roll, foot orthotics, retainer on teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	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(es) below and explain in Responses section.	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently under a doctor's care for a specific illness, injury or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you unsatisfied with your current weight? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any allergies (ex: pollen, medicine, food, stinging insects)? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been dizzy during or after exercise?	<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"/>
10. Do you have any current skin problems (ex: itching, rashes, acne, warts fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you have any other medical conditions not previously mentioned (ex: diabetes, thyroid disease, immune disorders, bleeding disorder, etc)?	<input type="checkbox"/>	<input type="checkbox"/>
			<b><u>MALES ONLY</u></b>		
			20. Do you have two testicles?	<input type="checkbox"/>	<input type="checkbox"/>
			21. Do you have any testicular swelling or masses?	<input type="checkbox"/>	<input type="checkbox"/>
			<b><u>FEMALES ONLY</u></b>		
			22. 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? _____		

**RESPONSES** (explain yes answers; use another sheet if necessary)

**CIRCLE ALL SPORTS IN WHICH THE STUDENT IS ALLOWED TO PARTICIPATE:**

Football    Volleyball    Baseball    Wrestling    Basketball    Golf    Soccer    Softball    Tennis    Cross Country    Track & Field    Swimming & Diving    Cheer

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. Our signatures indicate we have read, understand, and agree with the entire document including the Medical History, Steroid Agreement, UIL Rules, UIL Parent Information Manual, Concussion Information, Insurance Information, and Parent Permit.

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor: \_\_\_\_\_  
*Signature*

School Official: \_\_\_\_\_  
*Signature*

## Eanes ISD Pre-Participation Physical Evaluation Form

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_

BP	/	/	/
%	/	/	/

brachial blood pressure while sitting

BMI % \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected:  Y  N

Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

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			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Marfan's stigmata (arachnodactyly, pectus, excavatum, joint hypermobility, scoliosis)			

\*station based only

**CLEARANCE**

Cleared  Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_

Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

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*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: \_\_\_\_\_

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

**SIGNATURE ALSO REQUIRED BELOW MEDICAL HISTORY ON FRONT OF FORM**