KLEIN INDEPENDENT SCHOOL DISTRICT PRE-PARTICIPATION FORM

*****PLEASE PRINT LEGIBLY WITH BLUE OR BLACK INK*****

***** THIS FORM AND ALL ONLINE FORMS MUST BE COMPLETE AND ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, BEFORE, DURING OR AFTER SCHOOL, (BOTH IN-SEASON AND OUT-OF-SEASON) OR PERFORMANCE /GAMES/MATCHES. *****

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

KISD Student ID # **Gender** **Age** **Date of Birth** **Grade**

Allergies: _____ **Medication taken regularly:** _____

Medical Concerns (May be asked for physician documentation): _____

School Attended 2019-2020 School Year: _____ **Circle Applicable: Athletics Other Activities**

Current School Attending: _____ **Current Sport (List all that apply):** _____

Student Home Street Address **City** **Zip Code**

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

Alternate Contact FULL Name (Any) *(include last name)* **Emergency Contact – Phone #** **Relation to student**

PRE-PARTICIPATION PHYSICAL REQUIREMENT

UIL requires this Pre-participation Physical Form *MUST* be completed prior to junior high athletic participation and again prior to first year of high school athletic and fine arts participation. Klein ISD requires a physical exam and medical history for each school year.

CONSENT TO TREAT

If, in the judgement of any representative of the school, the above student should need immediate care and treatment because of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, school representative, contracted provider or contracted medical service. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person because such care and treatment of said student. I hereby state that, to the best of my knowledge, all my answers to the questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL & KISD. 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.

RETURN TO PARTICIPATION AFTER ANY MEDICAL CONSULTATION (DOCTOR VISITS)

Athletes who seek medical attention from a Healthcare Provider for any injury or illness, 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 injury and illness that may not be school related, i.e. Club or off campus sports. The doctor note should include a diagnosis and include any restrictions.

Once ALL electronic forms have been submitted (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, or Activity Director, THEN the student will be eligible (Cleared) to participate in any practice, scrimmage, performance or contest before, during or after school. Contact your Campus AT, Coordinator or Activity Director with any questions.

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

For the School Personnel Use Only (Campus Athletic Trainer or Intermediate Head Coach)

Medical History Form was reviewed by Name: _____ **Date:** _____

Student Name: _____ Age: _____ DOB: _____ 2019-20 Grade: _____

PRE-PARTICIPATION MEDICAL HISTORY/ PHYSICAL EXAM – FILL IN ALL BLANKS

STUDENT – PARENT/GUARDIAN SECTION

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent/guardian and student in order for the student to participate inactivities. These questions are designed to determine if the student has developed any condition, which would make it hazardous to participate in an 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
Have you ever been diagnosed with/or treated for **sickle cell trait or disease**?	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)_____	O	O
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. Have you been diagnosed with Diabetes? Type _____	O	O
8. Are you **currently taking any prescription or non-prescription** (over-the-counter) **medication or pills or using an inhaler**?	O	O
9. Do you have any **allergie**s (for example, to pollen, medicine, food, or stinging insects)?	O	O
10. Have you ever been **dizzy** during or after exercise?	O	O
11. Do you have any current **skin problems** (for example, itching, rashes, acne, warts, fungus, or blisters)?	O	O
12. Have you ever become ill from exercising in the heat?	O	O
13. Have you had any problems with your **eyes or vision**?	O	O
14. 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
15. 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
16. 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		
17. 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
18. Do you feel stressed out?	O	O

19. ***Females Only:***

a) When was your **first** menstrual period? _____

b) When was your **most recent** menstrual period? _____

c) How much time do you usually have from the start of one period to the start of another? _____

d) How many periods have you had in the last year? _____

e) What was the longest time between periods in the last year? _____

20. Males Only (Yes/No):

a) Do you have two testicles? _____

b) Do you have any testicular swelling or masses? _____

MEDICAL EXAMINER SECTION

It must be completed if there are "**yes"** answers to specific questions on the student's MEDICAL HISTORY FORM in the left column.

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: _____

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

I certify that everything I have recorded in the above medical history is to the best of my ability known as true. I do not hold any entity responsible for any injuries associated with an invalid medical history. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL.

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