

**HOUSTON INDEPENDENT SCHOOL DISTRICT  
ATHLETIC DEPARTMENT**

Revised  
01/03/2005

**PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY**

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 whether the student has developed any condition that would make it hazardous to participate in an athletic event.

Student's Name \_\_\_\_\_ 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 below. Circle questions you don't know the answers to.

	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"/>	10. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year? Have you had surgery in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>	12. 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"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	13. 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 and explain below.	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do 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, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or an abnormal heart rhythm? Have you had a severe viral infection (for example, 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"/>	<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	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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 below) 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"/>	15. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever gotten unexpectedly short of breath with exercise? Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	17. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Females Only</i>		
			18. 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? _____		
			Explain "Yes" answers here: _____ _____ _____ _____		

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 Houston Independent School District 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 physician, 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.

To the parent:                       Baseball                       Football                       Softball                       Tennis                       Wrestling  
 Check any activity this student    Basketball                       Golf                       Swimming and Diving                       Track and Field  
 should be excluded from.         Cross-Country                       Soccer                       Team Tennis                       Volleyball

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

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

**HOUSTON INDEPENDENT SCHOOL DISTRICT  
ATHLETIC DEPARTMENT  
PHYSICAL EXAMINATION FORM**

The physical examination must be performed by a physician licensed to practice medicine in the state of Texas under the Medical Practice Act, i.e., a medical doctor (M.D.) or a doctor of osteopathy (D.O.). The University Interscholastic League and HISD rules require this report to be completed and the exam to have been passed before a student participates in any tryouts, practices, games, or off-season programs.

When in the judgment of school staff members there appears to be a change in the physical status of an athlete after the physician's report is completed, the school may require another physical examination, and a release by the physician must then be obtained before an athlete will be allowed to continue in an activity.

**Physicals must be completed no sooner than May 15 preceding the current school year.**

Student's Name: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L/20 \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
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			

Previous surgery \_\_\_\_\_

Is student taking any medication routinely?  Yes  No (If yes, explain) \_\_\_\_\_

Allergic to any medication? \_\_\_\_\_

**CLEARANCE**

Cleared: \_\_\_\_\_

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

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

**Do not sign if student fails physical.**

\_\_\_\_\_  
Stamp (or print) Name of Physician

\_\_\_\_\_  
Signature of Examining Physician (M.D. or D.O. only)

\_\_\_\_\_  
Address Phone #

\_\_\_\_\_  
Date of Physical Examination

Original for school file  
Copy for Stadium Athletic Trainer  
Copy for physician, if needed

\_\_\_\_\_  
State License Number