PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

2020

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an 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.

	Yes	No
1. Have you had a medical illness or injury since your last check up or physical?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
Have you ever had surgery?	☐	☐
3. Have you ever had prior testing for the heart ordered by a physician?	☐	☐
Have you ever passed out 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 unexplained death before age 50?	☐	☐
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?	☐	☐
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 activities for any heart problems?	☐	☐
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 your 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?	☐	☐
5. Are you missing any paired organs?	☐	☐
6. Are you under a doctor's care?	☐	☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐

	Yes	No
13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
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 and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16. Do you want to weigh more or less than you do now?	☐	☐
17. Do you feel stressed out?	☐	☐
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

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? _____

Males Only

20. Are you missing a testicle? _____

21. Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by athletes, 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 participation, 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, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

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 participation and again prior to first and third years of high school 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*
MEDICAL			
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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

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 performance/ games/matches.

SCURRY-ROSSER INDEPENDENT SCHOOL DISTRICT

Student Medical / Emergency Information Card

Student's Name _____ Date _____

Address _____ Birth Date_____ Sex:_____

TO PARENT OR GUARDIAN: To serve your child in case of accident or illness, please furnish the following information:

Father's Name _____ Father's Home Phone# _____

Cell Phone # _____ Work Phone # _____

Mother's Name _____ Mother's Home Phone # _____

Cell Phone # _____ Work Phone # _____

List two persons who will assume temporary care of your child if you cannot be contacted.

Name _____ Phone # _____

Name _____ Phone # _____

Doctor _____ Phone # _____

Dentist _____ Phone # _____

Guarantor's _____

INSURANCE COMPANY PHONE # NAME OF INSURED

_____

EMPLOYER GROUP# INDIVIDUAL POLICY #

I, the undersigned, do hereby authorize employees of Scurry-Rosser Independent School District to contact directly the persons and health care providers named on this card, and do authorize the named physicians, clinics, and/or hospitals to render such treatment as may be deemed necessary for the transportation and health care of said child. In the event the physicians, other persons named on this card, or parents cannot be contacted, the school employees are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. (Section 35.01, Texas Family Code) I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

I request that the physicians, dentists and staff of the medical facility perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatments and anesthetics as may be necessary in the diagnosis and treatment of my child. I understand that I must notify Scurry-Rosser I.S.D. in writing to change any information on this form or to revoke any consent given herein. I testify all information on this document to be true and correct.

If a valid notary signature appears below, a copy of this document should be considered as valid as the original. Original forms are on file in the SRISD athletic office and available for inspection upon request.

I do _____ or do not _____ carry insurance on _____

Athlete's Name

OVER THE COUNTER MEDICATION APPROVAL

The following Over the Counter (OTC) medications are provided for your student/athlete **ONLY** with your permission. Please indicate with a **CHECK** any medicines you wish to be **WITHELD** from your child.

____ Alcalak (Antacid) ____ Diotame (Pepto Bismol)

____ Ibuprofen (Advil) ____ APAP (Tylenol)

____ Diamode (Imodium AD) ____ Medikoff Drop (cough drops)

____ Diphen (Benadryl) *Only given in case of severe allergic reaction*

Prescription Medications Currently Taking: _____

Allergic Reactions to Medications _____

THIS FORM MUST BE SIGNED IN FRONT OF A NOTARY PUBLIC BEFORE TURNING INTO THE SCHOOL

PRINTED NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

STATE OF TEXAS, COUNTY OF _____ SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DAY OF _____ A.D _____.

_____

Notary Public Signature

Scurry-Rosser I.S.D.

Athletic Department

To the Parents/Guardians of Scurry-Rosser I.S.D. Athletes:

Your son/daughter should have adequate health/accident insurance before participating in the Scurry-Rosser athletic program.

I, _____ (parent/guardian), understand that the cost accrued as a result of any injury resulting from participation in athletics is my responsibility. With that understood, I certify that we have adequate insurance for our son/daughter, _____.

(Print Student's Name)

_____ _____

Signature of Parent/Guardian **Date**

_____ _____

Signature of Notary **Date**

Notary Seal

SCURRY - ROSSER INDEPENDENT SCHOOL DISTRICT

DRUG TESTING AUTHORIZATION

ALL COMPETITION EXTRACURRICULAR PARTICIPATING STUDENTS

Student's Name _____ Social Security #_____

AS A PARTICIPATING STUDENT

- I understand and agree that participation in extracurricular activities is a privilege that may be withdrawn for violations of the Scurry-Rosser Independent School District Drug Testing Policy.
- I have read the Scurry-Rosser Independent School District Drug Testing Policy and thoroughly understand the consequences that I will face if I do not honor my obligations under the drug testing policy.
- I understand that when I participate in Competition Extracurricular Activities, as defined in the Drug Testing Policy, I will be subject to initial and random drug testing. If I refuse testing, such refusal will be treated the same as a positive drug test. I have read the content of the Consent to Perform Drug Testing for Extracurricular Activities and agree to its terms.
- I understand this is a binding agreement while a student in the Scurry-Rosser Independent School District.

Student Signature: _____ **Date:** _____

AS A PARENT/GUARDIAN/CUSTODIAN

- I have read the Drug Testing Policy and understand the responsibilities of my son/daughter/ward as a participant in the COMPETITION EXTRACURRICULAR ACTIVITIES in the Scurry-Rosser Independent School District.
- I pledge to promote healthy life styles for all students in the school district.
- I understand that my son/daughter/ward when participating in Competition Extracurricular Activities, will be subject to initial and random drug testing. I also understand the consequences that they will face if they refuse to honor their obligations under the drug testing policy.
- I understand this is a binding agreement while my son/daughter/ward is a student in the Scurry-Rosser Independent School District.

Listed below are the prescription drugs and dosages my son/daughter takes on a regular basis. I understand that, depending on the type of medication and the circumstances, its use may have to be verified and discussed with the doctor who prescribed it. I give permission for the doctor(s) who prescribed medication for my daughter/son/ward's medical condition(s) to verify the circumstance and discuss any effects that the medication(s) may have on my son/daughter/ward's lab test results or school performance.

Drug Name: _____ Dosage: _____

_____ _____

_____ My son/daughter does not take any prescription medication on a regular or permanent basis.

Parent/Guardian Signature: _____ **Date:** _____

SCURRY - ROSSER INDEPENDENT SCHOOL DISTRICT

CONSENT TO PERFORM DRUG TESTING

ALL COMPETITION EXTRACURRICULAR PARTICIPATING STUDENTS

I/we hereby consent to allow _____ to undergo drug testing for the presence of illicit drugs or banned substances in accordance with the Policy and Procedures for the Drug Testing of Scurry-Rosser Independent School District students as approved by the Scurry-Rosser Independent School District Board of Trustees.

We understand that a qualified vendor will oversee the collection process.

We understand that any urine samples will be sent only to a certified laboratory for testing, and that the samples will be coded to provide confidentiality.

We hereby give our consent to the vendor selected by the Scurry-Rosser Independent School District, its Doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical vendor to perform drug testing for the detection of illicit drugs or banned substances.

We further give permission to the vendor selected by the Scurry-Rosser Independent School District, its doctors, employees, or agents, to release all results of these tests to the Scurry-Rosser Independent School District. We understand these results will be forwarded to the superintendent or designee and will be made available to us.

We understand that consent pursuant to this Informed Consent Agreement will be effective for all Participating Students In Competition Extracurricular Activities as defined in the Drug Testing Policy.

We hereby release the Scurry-Rosser Independent School District Board of Education and it's employees from any legal responsibility or liability for the release of such information and records.

_____ _____

Parent/Guardian Signature **Date**

Scurry-Rosser Independent School District
Spectator Code of Conduct

The Scurry-Rosser ISD Athletic Department would like to issue the following statement regarding spectator conduct at athletic contests.

The contests in which our students participate are for their educational benefit. We appreciate the support of the school community when they cheer and applaud the participants, coaches, and officials. By doing so, you honor the players, coaches, and officials for their effort and time preparing for this educational experience. We also ask that you show your appreciation for the cheerleaders, band members, drill team and other students who participate and support school events.

The officials for this game have been mutually agreed upon by each school district. We ask that you demonstrate the kind of respect for these officials you would extend to any dedicated person in a position of responsibility.

As a spectator you should **NOT**:

- **Criticize players, coaches or officials; or distract others away from the event**
- **Behave inappropriately for a school setting**
- **Possess or be under the influence of alcohol, tobacco or drugs on school property**
- **Be discourteous or pose a risk of harm towards any person**

Scurry-Rosser ISD will use any of the following options for **VIOLATIONS** of the Spectator Code of Conduct:

- **Issue verbal warning during the event as necessary**
- **Remove persons from the current event for violating this code**
- **Consult with individuals who have violated this code**
- **Suspend persons from future events, for up to 2 years, who violate this code**

Scurry-Rosser ISD reserves the right to remove any person for violating the Spectator Code of Conduct or for actions deemed detrimental to a school event.

Board Policies GKA Legal (Conduct on School premises), GF Legal/Local (Public Complaints), and FNG Legal/Local (Student and Parent Complaints) govern regulations concerning public access to school events and are located on the school district website (scurry-rosser.com). Please contact the Athletic Office or Campus Office for assistance.

John David Caffey, Athletic Director, SRISD

_____ _____

Parent Signature **Date**