



HUMBLE INDEPENDENT SCHOOL DISTRICT  
UIL ATHLETIC PARTICIPATION FORM  
2018-2019

Receipt# \_\_\_\_\_  
Phys Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_  
Sport(s): \_\_\_\_\_  
Person Completing Receipt: \_\_\_\_\_

**A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER BEFORE A STUDENT ATHLETE CAN PARTICIPATE IN ANY ATHLETIC ACTIVITY** This **MEDICAL HISTORY FORM** must be completed annually by parent/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. **Physicals for the 2018-2019 school year must be performed on or after February 1, 2018 Physicals preformed before this date WILL NOT BE accepted for the 2018-19 school year.**

**ATHLETE INFO:**

Last Name: \_\_\_\_\_ (legal) First Name: \_\_\_\_\_ (legal) MI: \_\_\_\_\_  
Student ID: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade (2018-19): \_\_\_\_\_ Age: \_\_\_\_\_  
Gender:  male  female Home phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Athlete's cell phone: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Address: \_\_\_\_\_ city: \_\_\_\_\_ zip: \_\_\_\_\_  
Athlete's email: \_\_\_\_\_@\_\_\_\_\_  
School attending in 2018-19: \_\_\_\_\_ what sport(s): \_\_\_\_\_  
Personal physician: \_\_\_\_\_ phone: \_\_\_\_-\_\_\_\_-\_\_\_\_  
**Check all that apply:**  requires epi pen  asthma  requires inhaler  diabetes  insulin dependent  
 epilepsy  heart disease  any heart condition  sickle cell  
**O REQUIRED MED'S:** \_\_\_\_\_  
**O Drug/Food Allergies:** \_\_\_\_\_

**INSURANCE INFORMATION**

Humble Independent School District offers a Student Accident Insurance Policy for all Humble ISD athletes competing in an **UIL sponsored sport**. This insurance policy is **NOT** a replacement of any other insurance policy. This insurance policy is available to all student athletes. It is offered to assist in the diagnoses and/or treatment of any athletic related injuries. Injuries that are not school related athletic activities will not be covered by this insurance. This insurance is **secondary** to the insurance policy that the parent/or guardian has on the student athlete. This insurance is not designed to cover **all cost**, but to **aide** in the total cost of medical treatment. **It is the responsibility of the parent/guardian to request a claim form within 90 days of the injury, and to submit claim form to the insurance company.** Further information about this supplemental insurance can be found through the athletic trainer's office at the student athlete's campus.

Check here if this athlete is not covered under a primary health insurance at this time  
**Primary health insurance information:** Humble ISD provides a small secondary policy that may assist in the event of an injury that occurs in a UIL sponsored event. Before we can apply a secondary claim, we must first have all of the following information.

Insurance Company Name:: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Plan: \_\_\_\_\_  
ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ NETWORK #: \_\_\_\_\_  
Address: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COVERAGE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PARENT / GUARDIAN #1:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: : (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Alternate Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Full Name of Employer or Company: \_\_\_\_\_  
O CHECK HERE IF HOME ADDRESS SAME AS ATHLETE  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
PARENT / GUARDIAN EMAIL: \_\_\_\_\_@\_\_\_\_\_  
Does this athlete live with you: (CIRCLE) YES NO

**PARENT / GUARDIAN #2:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: : (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Alternate Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Full Name of Employer or Company: \_\_\_\_\_  
O CHECK HERE IF HOME ADDRESS SAME AS ATHLETE  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
PARENT / GUARDIAN EMAIL: \_\_\_\_\_@\_\_\_\_\_  
Does this athlete live with you: (CIRCLE) YES NO

**Emergency Contact:** Please list an emergency contact other than the above parent/guardian, so that in the event we can not contact the parent/guardians, we will have an alternate number and someone else to help us contact the parent/guardian.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ EXT: \_\_\_\_\_

Answer each question on an individual bases as it pertains to the **ATHLETE**. Enter a check for the appropriate response or quantitative numbers where appropriate.

Circle questions you don't know the answers to. Any **YES** answer may require further medical evaluation which may include a physical examination.

	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. Do you have any current skin problems? (itching, rashes, acne, warts, fungus, blisters)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever 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?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you have asthma?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Is an inhaler required by your physician?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>(If Yes, student MUST have Inhaler Action Plan on with the school nurse)</b>		
Have you ever had racing heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or have had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment of devices that aren't usually used for your sport or position (ex: knee brace, special neck roll, foot, orthotics, retainer for your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member been diagnosed with enlarged heart hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with pain or swelling in muscles, tendons, bones, joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
<b>Has a physician ever denied or restricted your participation in sports for any heart related problems?</b>	<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"/> Thigh <input type="checkbox"/> Back		
<b>4. Have you ever had a head injury or concussion?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Upper Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm		
If YES, how many times? _____			16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
When was the last concussion? _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain on a separate sheet of paper) time missed, hospital visit, specialist			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<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"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever been diagnosed with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	YES Type I ____ or Type II ____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only:		
<b>5. Are you missing any paired organs?</b>	<input type="checkbox"/>	<input type="checkbox"/>	20. When was your first menstrual period? _____		
<b>6. Are you under a doctor's care?</b>	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
7. 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"/>	How much time do you usually have from the start of one period to the start of another? _____		
8. Do you have any allergies? (ex: to pollen, medicine, food, or stinging insects)	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
<b>Do you require an Epi Pen?</b>	<input type="checkbox"/>	<input type="checkbox"/>	What the longest time between periods in the last year? _____		
9. Have you ever become dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	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 ON THE BACK PAGE OF THIS DOCUMENT:**

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

**Release:** In the event that the parents or legal guardians of the above named child cannot be contacted, I do hereby accept the emergency services of the team physician and/or the athletic trainer. 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 the said student

**X**

Parent 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.

Name: \_\_\_\_\_ **Medical Examiner Section**  
 Humble ISD requires an annual physical exam Sex: \_\_\_ Age: \_\_\_ Date of Birth: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_:\_\_\_\_\_/\_\_\_\_\_)  
 Vision: R -20/\_\_\_\_ L-20/\_\_\_\_ Corrected: Y N Contacts / Glasses 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.**

Medical	Normal	Abnormal	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			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

Musculoskeletal	Normal	Abnormal	Initials
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: \_\_\_\_\_

**NOTE OF CLEARANCE MUST BE ON LETTERHEAD OF CLEARING PHYSICIAN**

*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.*

Physician's Signature: \_\_\_\_\_ Name: (print/type): \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Physicians Stamp**

Please write an explanation for all "YES" answers on the Medical History page in the space provided below.

**\*\*INCOMING FRESHMAN ONLY\*\***

**ELECTROCARDIOGRAM SCREEN (ECG) CONSENT FORM AND RELEASE OF LIABILITY**

An ECG screen (sometimes also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death. An ECG screen may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

By signing below, I am either electing or declining an ECG screen provided by the Humble Independent School District for my child. These screenings are provided with help of Memorial Hermann Northeast Hospital. These screening will only be provided with cost of a regular physical done through each high school in Humble ISD. By electing to receive an ECG screen, I acknowledge the limitations of an ECG screen and that sudden cardiac death is still possible, despite this screening. I further acknowledge that students with an abnormal ECG screen will be required to perform further testing and/or a medical consultation prior to being released to resume participation for HISD activities. By my signature below, I hereby release and forever discharge, and waive, any and all claims against the Humble Independent School District, its employees, trustees, consultants and contractors that relate to the student's election regarding and/or participation in the ECG screening project, and authorize medical personnel to review the ECG results, and interpret and use the same for diagnostic and aggregated statistical purposes in addition to other medical documentation on file in with the school district, and in accordance with the Family Educational Privacy Rights Act and the Health Insurance Portability and Accountability Act of 1996.

I DO hereby consent to participation in the ECG screen on behalf or that of my minor child.

I DECLINE participation in the ECG screen on behalf or that of my minor child.

**This Document must be fully completed and submitted by the child when the physical is turned in. The ECG will only be offered by Humble ISD at the 5 high school sites on their designated physical day dates and times. If a student misses these dates and times they will be responsible for setting up their own appointment to get the ECG preformed and evaluated.**

X \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_  
Child's Name Printed Student's Signature

X \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Name Printed Parent/Guardian Signature

**High School Students (Incoming Freshman- Seniors)**

Athletic physicals should be turned into your school's Athletic Trainers. NO Physicals should be turned into front offices or coaches.

**Middle School Students (Incoming 7<sup>th</sup>- 8<sup>th</sup> graders)**

Athletic physicals should be turned into you Head coach only. Please do not turn physicals into the front office.

**Over the summer physicals can be turned in at the Humble ISD Main Athletic Office on Wednesdays from 10AM to 2PM**

**If you have any questions please contact the Athletic Trainer at your High School**

**Atascocita  
281-641-7681**

**Humble  
281-641-6510**

**Kingwood  
281-641-7028**

**Kingwood Park  
281-641-6738**

**Summer Creek  
281-641-5441**