HUMBLE INDEPENDENT SCHOOL DISTRICT
UIL ATHLETIC PARTICIPATION FORM
2017-2018

Receipt# _____
Phys Date: ____/____/____ **Grade:** _____
Sport(s): _____
Person Completing Receipt: _____

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER BEFORE A STUDE 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 2017-2018 school year must be performed on or after February 1, 2017 Physicals preformed before this date WILL NOT BE accepted for the 2017-18 school year.**

ATHLETE INFO:

Last Name: _____ **(legal) First Name:** _____ **(legal) MI:** _____

Student ID: _____ **Date of birth:** ____/____/____ **Grade (2017-18):** _____ **Age:** _____

Gender: o male o female **Home phone:** ____-____-_____ **Athlete's cell phone:** ____-____-_____

Address: _____ **city:** _____ **zip:** _____

Athlete's email: _____@_____

School attending in 2017-18: _____ **what sport(s):** _____

Personal physician: _____ **phone:** ____-____-_____

Check all that apply: o requires epi pen o asthma o requires inhaler o diabetes o insulin dependent o epilepsy o heart disease o any heart condition o 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.

O Check heck 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 thank 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: _____

Student Name: _____ 2017-2018

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
1. Have you had a medical illness or injury since your last check up or sports 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 pains during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing heart or skipped heartbeats?	☐	☐
Have you have or have 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 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 related 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 the last concussion? _____		
How severe was each one? (Explain on a separate sheet of paper) time missed, hospital visit, specialist		
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? (ex: to pollen, medicine, food, or stinging insects)	☐	☐
Do you require an Epi Pen?	☐	☐
9. Have you ever become dizzy during or after exercise?	☐	☐

	Yes	No
10. Do you have any current skin problems? (itching, rashes, acne, warts, fungus, blisters)	☐	☐
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you ever had any problems with your eyes or vision?	☐	☐
13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you have asthma?	☐	☐
Is an inhaler required by your physician? (If Yes, Must have Inhaler Action Plan on with the school nurse)	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
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 problems with pain or swelling in muscles, tendons, bones, joints?	☐	☐

If yes, check appropriate box and explain below:

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

16. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
17. Do you feel stressed out?	☐	☐
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐
19. Have you ever been diagnosed with diabetes? YES Type I ___or Type II____	☐	☐

Females Only:

20. 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 the longest time between periods in the last year? _____

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.

Campus 17-18: **Sport(s):** **Grade (17-18):**

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

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

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

Please turn physical into Athletic Trainer on the High School Campuses or Coach on Middle School Campuses

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

School	Athletic Trainers	Office Number
Atascocita	**Jennifer Hampton**	**281-641-7681**
	Colby Harris	**281-641-7655**
Humble	**Mike Romig**	**281-641-6510**
	Russ McAdams	**281-641-6510**
Kingwood	**Pete Daigle**	**281-641-7028**
	Donna Brinegar	**281-641-7245**
Kingwood Park	**Daniel Scalia**	**281-641-6738**
	Leanna Rockwell	**281-641-6726**
Summer Creek	**Jennifer Barrett**	**281-641-5441**
	Matt Coleman	**281-641-5441**