

# McKinney Independent School District UIL Physical Exam Form

**Please Print**

**Student**

Name: \_\_\_\_\_  
Last
First
M.I.

Circle Grade for 2008-09 School year:    7            8            9            10            11            12

Sex: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street
City
State
Zip Code

**Parent/Guardian Information:**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Workplace: \_\_\_\_\_ Father's Workplace: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT OR GUARDIAN'S PERMIT**

- I do hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.
- 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 MISD assumes any responsibility in case an accident occurs.
- I undersigned to be responsible for the safe return of all athletic equipment issued by the school to the above named student
- If, in the judgment of any representative of the school, the above student needs immediate care and treatment as a result to injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; an I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.
- **I have been given the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.**

Your signature below gives authorization that is necessary for the school district, it's athletic trainer's, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment of your student.

**Parent/  
Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

School Attending 2008-09

First Name

Last Name

# PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

Student Name: \_\_\_\_\_  
Last
First
M.I.

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Question	Yes	No	Explain any "Yes" Answers Here
1. Have you had a medical illness since your last check up or sports physical? When			
2. Have you been hospitalized overnight in the past year? When?			
Have you had surgery in the past year? When			
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pill or using an inhaler?			
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			
5. Have you ever passed out during or after exercise?			
Have you ever been dizzy during or after exercise?			
Do you ever had chest pain during or after exercise?			
Do you get tired more quickly than your friends 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 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?			
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?			
7. Have you ever had a head injury or concussion?			
Have you ever been knocked out, become unconscious, or lost you memory?			
If yes, how many times? _____ When was the last concussion? _____ How severe was each one?			
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?			
8. Have you ever become ill from exercising in the heat?			
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?			
10. Have you had any problems with your eyes or vision?			
11. Are you missing any paired organs?			
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)			
13. Have you ever had a sprain, or strain, or swelling after injury?			
Have you broken or fractured any bones or dislocated any joints?			
<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"/> 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"/> Foot <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Upper Arm			
14. Do you want to weigh more or less than you do now?			
Do you lose weight regularly to meet weight requirements for you sport?			
15. Do you feel stressed out?			
16. Record the dates of your most recent immunizations (shots) for: Tetnus _____ Measles _____ Hepitius B _____ Chickenpox _____			
17. Are you under a doctor's care?			
18. Do you have sickle cell anemia			
19. Is there a history of sickle cell anemia in your family?			

**FEMALES ONLY:**

When was your first menstrual period? \_\_\_\_\_ When was your most recent 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? \_\_\_\_\_

**An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question five 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.**

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 high 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 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 to penalties determined by the UIL.**

Student Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



**INSURANCE**

McKinney I.S.D. does provide limited accident insurance coverage for all 7<sup>th</sup> through 12<sup>th</sup> grade students who participate in any U.I.L. sanctioned activity. **The insurance provided by the school is for activities that are sanctioned by UIL rules and regulations. Any competition in which the student participates that is NOT under UIL sanction will NOT be covered under school insurance.** However, parents must still resume the responsibility for any injury sustained, regardless of what any insurance company pays. This policy is not intended nor written to cover all expenses incurred, but to serve only as an excess secondary insurance policy. The injury is to be reported to the high school athletic trainer and coach the day of injury. Treatment must begin within 30 days from the injury and claims must be filed within 90 days of the injury. **It is the responsibility of the parent or guardian to file a claim.** An insurance claim form may be obtained from a high school Athletic Trainer or Middle School Athletic Coordinator.

Family Insurance	Name of Insured	Family Physician Phone ( )
Policy Number	Expiration Date	Social Security Number

**STUDENT ATHLETE INJURY AND/OR ILLNESS REPORT**

Any student athlete visiting a licensed medical provider for an illness or injury must obtain a report signed by said **physician** containing the following information.

- Nature of illness or injury
- Treatment of illness or injury including medication, protective gear, etc.
- Specific instructions regarding any restrictions from full participation in athletics, (e.g. may participate in non-contact environment, may not participate at all, etc.)
- Date of release that student athlete may participate in athletics with no restrictions.
- The team physician together with a licensed athletic trainer shall have the final decision determining if the athlete will participate or play.

**This signed report is to be submitted to the athletic trainer upon return to school, prior to any or all participation. A copy of clearance form must be obtained by the Sports Medicine Staff and presented to appropriate coach prior to activity.**

**HEAD INJURY POLICY**

Any student athlete receiving three significant concussions within a calendar year could result in restricting the athlete from participation in athletics for that season.

A significant concussion is defined as a head injury with prolonged symptoms of a head injury lasting a week or more.

The release of the student athlete to participate in athletics shall be based upon further exam, CAT scan, and MRI that prove to be negative. Each case shall be evaluated on individual circumstances as to whether or not the student athlete is released to participate fully.

**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 participation. I agree to notify the school authorities of such illness or injury.**

**I have read and understand the Insurance, Student Injury/Illness Report and Head Injury Policy. I do hereby agree that my son/daughter will abide by said rules. I also hereby state that, to the best of my knowledge, my answers to the Medical History questions are complete and correct:**

<b>Student Signature</b> _____	<b>Date</b> _____
<b>Parent/Guardian Signature</b> _____	<b>Date</b> _____

**THE FOLLOWING MUST BE SIGNED BY EACH FOOTBALL PARTICIPANT AND PARENT**

**WARNING** No helmet can prevent all head and neck injuries a player might be exposed to while playing football. DO NOT use helmet to butt, ram, spear an opposing player. This is a violation of the football rules and such use can result in severe head or neck injuries, paralysis or death to you and possible injury to your opponent.

I have read and understand the above safety warning

<b>Student Signature</b> _____	<b>Date</b> _____
<b>Parent/Guardian Signature</b> _____	<b>Date</b> _____

**MC KINNEY INDEPENDENT SCHOOL DISTRICT ATHLETIC DEPARTMENT  
EMERGENCY PROCEDURES AND ORAL MEDICATION CARD**

In case of injury or serious illness, I hereby grant permission for school employees to secure medical services for the student below throughout the 7-12 grade. I also give permission for the medication I have checked on the reverse side of this card to be administered by the Team Physician, Athletic Trainer, and/or Coach as necessary to keep a student in optimum health for maximum performance.

Sport(s) \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ Grade \_\_\_ School Year \_\_\_-\_\_\_

Student's Name \_\_\_\_\_  
(Last) (First) (Middle)

Home Address \_\_\_\_\_  
(Street) (City) (Zip)

Home Phone(\_\_\_\_) \_\_\_\_\_

Father's Work Phone (\_\_\_\_) \_\_\_\_\_ Mother's Work Phone (\_\_\_\_) \_\_\_\_\_

Father's Cell Phone (\_\_\_\_) \_\_\_\_\_ Mother's Cell Phone (\_\_\_\_) \_\_\_\_\_

Please answer the following questions with either Yes-No-or the appropriate answer:

Blood type \_\_\_ Diabetes \_\_\_ Heart Trouble \_\_\_ Epilepsy \_\_\_ Contact/Glasses \_\_\_ Drug Allergies \_\_\_\_\_

Group Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

Family Physician: \_\_\_\_\_ Physician Phone(\_\_\_\_) \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**(Please fill out Oral Medication on reverse side)**

**ORAL MEDICATION RELEASE CARD**

	Yes	No
I. Electrolyte Supplements		
1. Electrolyte Drink; (Quickkick, Gatorade, etc.).....	___	___
2. Fos-Free (Calcium, Iron, & vitamins to prevent muscle cramps)...	___	___
II. Anti-inflammatory:		
1. Ibuprofen (Advil, etc.).....	___	___
2. Acetaminophen (Tylenol, etc.).....	___	___
III. Antacids/Anti-Nausea & Diarrhea		
1. Mylanta (Reduces heartburn, Sour Stomach, and Acid Indigestion)	___	___
2. Pepto-Bismol (Heartburn, Nausea, Diarrhea, contains aspirin)...	___	___
IV. Cold & Sinus		
1. Cepacol (Temporary relief of sore throat).....	___	___
2. Chloraceptic (Temporary relief of sore throat).....	___	___
3. Cold Tablets (Temporary relief of cold symptoms).....	___	___
4. Benadryl (Allergy & Sinus).....	___	___
5. Robitussin (Cough relief).....	___	___
V. Other medications prescribed by Family or Licensed Physician.....	___	___

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_