Paid:

PASADENA INDEPENDENT SCHOOL DISTRICT
PHYSICAL FORM

2013-14

Please use Blue/Black ink and Print legibly
Fill in all BLANKS…If items do not apply please write N/A

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE SPONSOR BEFORE A STUDENT CAN PARTICIPATE IN **ANY ACTIVITY** WHICH INCLUDES TRY-OUTS, OFFSEASON, PRACTICE AND COMPETITION.
If you are participating in athletics too, You MUST fill out all necessary athletic physical paperwork (athletic physical and acknowledgement of rules and code of conduct) and turn in ALL PAPERWORK into the athletic trainer NOT the sponsor.

All Physicals must be an **ORIGINAL** (no copies, fax, etc.) and the **CORRECT SCHOOL YEAR**. NO PHYSICAL WILL BE PERFORMED OR ACCEPTED BEFORE March 15, 2013. It is the student's responsibility to update new information as soon as it becomes available. (New address, phone number, etc…)

Student ID #:_____ Gender: Male / Female Date of Birth: _____ Age: _____ Grade (2013-14):_____

Last Name: _____First Name: _____Home Phone: _____Cell Number: _____

Address: _____ City/Zip:_____

Circle the school that you will be attending in 2013-2014:

Intermediate School: Beverly Hills Bondy Jackson Miller Park View Queens San Jacinto South Houston Southmore Thompson

High Schools: Dobie Memorial Pasadena Sam Rayburn South Houston

Activity (Please circle)
Band Drill Team Cheer
ROTC

Male Parent/ Guardian: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ LIVES WITH: YES NO

Female Parent/Guardian: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ **LIVES WITH: YES NO**

EMERGENCY CONTACT: Please list the emergency contact **IN CASE** a parent/guardian **CANNOT** be reached: (**CAN NOT BE A PARENT**)
Name: _____ Home Phone: _____ Cell Phone:_____
Work Phone: _____ Relationship: _____
Family Physician: _____ Office Phone: _____

Please identify any medical conditions that the athlete has been diagnosed with:
Asthma ☐ **Heart Condition** ☐ **Heart Disease** ☐ **Epilepsy** ☐ **Sickle Cell** ☐ **Diabetes** ☐ **Other**

Please explain any other conditions not addressed above:
_____
Allergy to: _____ **Allergy to Medication:** _____

MEDICATIONS:
Please list ANY prescribed medications that the student-athlete is currently taking.
(Student Athletes carrying Inhalers must have a Student Asthma Action Plan on file with the Campus Nurse and/or Athletic Trainer.)

Asthma Inhaler/Medication: _____

Medication _____ Reason for Medication _____
Medication _____ Reason for Medication _____

PARENT/GUARDIAN PERMIT —— MEDICAL CONSENT —— HIPAA and FERPA Compliance

I hereby consent for _____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 Pasadena Independent School District assumes any responsibility in case an accident occurs. The undersigned agrees 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 should need immediate care and treatment as a result of any injury or sickness, I authorize the Pasadena Independent School District athletic staff as agent(s) for the undersigned to consent to such treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and 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.
Your signature gives authorization which is necessary for the district, its trainers, coaches, and student insurance personnel to share information concerning medical diagnosis and treatment. This is to conform with Federal guidelines, i.e. HIPAA and FERPA

X _____ **Parent / legal guardian signature**

_____ **Student signature**

_____ **Date**

PRE PARTICIPATION MEDICAL HISTORY/PHYSICAL EXAM – *REQUIRED*

STUDENT – PARENT/GUARDIAN SECTION

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 condition which would make it hazardous to participate in an athletic event.

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to. 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.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	O	O
2. Have you been hospitalized overnight in the past year?	O	O
Have you ever had surgery?	O	O
3. Have you ever passed out during or after exercise?	O	O
Have you ever had chest pain during or after exercise?	O	O
Do you get tired more quickly than your friends do during exercise?	O	O
Have you ever had racing of your heart or skipped heartbeats?	O	O
Have you had high blood pressure or high cholesterol?	O	O
Have you ever been told you have a heart murmur?	O	O
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	O	O
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?	O	O
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	O	O
Has a physician ever denied or restricted your participation in sports for any heart problems?	O	O
4. Have you ever had a head injury or concussion?	O	O
Have you ever been knocked out, become unconscious, or lost your memory?	O	O
If yes, how many times? _____ When was the last concussion? _____		
How severe was each one? (Explain)_____		
Have you ever had a seizure?	O	O
Do you have frequent or severe headaches?	O	O
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	O	O
Have you ever had a stinger, burner, or pinched nerve?	O	O
5. Are you missing any paired organs?	O	O
6. Are you under a doctor's care?	O	O
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	O	O
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	O	O
9. Have you ever been dizzy during or after exercise?	O	O
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	O	O
11. Have you ever become ill from exercising in the heat?	O	O
12. Have you had any problems with your eyes or vision?	O	O
13. Have you ever gotten unexpectedly short of breath with exercise?	O	O
Do you have asthma?	O	O
Do you have seasonal allergies that require medical treatment?	O	O
14. 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)?	O	O
15. Have you ever had a sprain, strain, or swelling after injury?	O	O
Have you broken or fractured any bones or dislocated any joints?	O	O
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below	O	O
O Ankle **O** Chest **O** Finger **O** Head **O** Forearm **O** Neck **O** Shoulder **O** Upper Arm **O** Back **O** Elbow **O** Hand **O** Hip **O** Foot **O** Shin/ Calf **O** Thigh **O** Wrist		
16. Do you want to weigh more or less than you do now?	O	O
Do you lose weight regularly to meet weight requirements for your sport?	O	O
17. Do you feel stressed out?	O	O
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	O	O
19. ***Females Only: 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		

MEDICAL EXAMINER SECTION

***PISD requires an annual physical exam.**

Height:_____ **Weight:**_____ **Pulse:**_____

BP:_____/_____ **(**_____/_____**:**_____/_____**)**
Brachial Blood Pressure while sitting

Vision: R – 20/_____ **L – 20/**_____ **Corrected: Y N**

Pupils: Equal/Unequal **%Body Fat (optional):**_____

Medical	**Normal**	**Abnormal Findings**	**Initials***
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart – Auscultation Standing			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hyper-mobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

** Station-based examination only*

O Cleared

O Cleared after completing evaluation/rehabilitation for:_____

O Not cleared for:_____

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.

Date of Examination:_____

Name (**print**/type):_____

Address:_____

Phone Number:_____

Physician's Signature:_____

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, physicians assistant, chiropractor, or nurse practitioner.

EXPLAIN 'YES' ANSWERS HERE (attach another sheet if necessary):

For School Use Only: **This Medical History Form was reviewed by:**

Printed Name _____ **Date**_____ **Signature**_____