Paid:

PASADENA INDEPENDENT SCHOOL DISTRICT
UIL ATHLETIC PARTICIPATION FORM
Please use Blue/Black ink and Print legibly
Fill in all BLANKS…If items do not apply please write N/A

2013-14

RECEIPT #

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER BEFORE A STUDENT ATHLETE CAN PARTICIPATE IN **ANY ATHLETIC ACTIVITY** WHICH INCLUDES TRY-OUTS, OFFSEASON, PRACTICE AND COMPETITION.

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 athlete'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

SPORT (s)

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: _____

HEALTH INSURANCE INFORMATION: Please provide Insurance Information for your student-athlete.

Insurance Company Name:_____Address:_____

City:_____ State:_____ Zip: _____Phone:_____

Policy and/or Group Identification Numbers:_____

☐ ← CHECK HERE IF THIS ATHLETE IS NOT COVERED UNDER HEALTH INSURANCE AT THIS TIME.

Pasadena Independent School District offers a Student Accident Insurance Policy for all Pasadena ISD athletes. 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 their campus.

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 _____

Medication _____ Reason for Medication _____

PRE PARTICIPATION MEDICAL HISTORY/PHYSICAL EXAM – *REQUIRED*

Student's Name: _____ Sex_____ Age_____ Date of Birth _____

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

Must Include Physician stamp to be valid

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_____

INJURY INFORMATION:

If the athlete is referred to a physician, or chooses to visit a physician on their own, documentation must be provided to the proper people.

- High School: Athletic trainers
- Middle School: the Head Coach of the sport you are participating in.

The documentation is to include the following:

- Diagnosis
- Status – Not only what you can't do, but also what you can do.
- Treatment Options – High School Athletics only.
- Next appointment date.

This documentation is necessary to ensure that the athlete is medically able and cleared to participate. The guidelines outlined in the documentation will be the ones followed until another notice is received from the athletes' physician. If a coach or trainer discovers that an athlete was examined by a physician without providing documentation, they will not be allowed to participate or be provided further treatment or rehabilitation until the proper documentation is received

CONCUSSION ACKNOWLEDGEMENT

Definition of Concussion –

means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention –

Teach and practice safe play & proper technique.
– Follow the rules of play.
– Make sure the required protective equipment is worn for all practices and games.
– Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion –

The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight –

Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion –

The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to play protocol as determined by the Concussion Oversight Team.

Return to Play –

According to the Texas Education Code, Section 38.157:

A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:

(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;

(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;

(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and

(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:

(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;

(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and

(C) have signed a consent form indicating that the person signing:

(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;

(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;

(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and

(iv) understands the immunity provisions under Section 38.15

 _____  _____ _____

Parent or Guardian Signature **Student Signature** **Date**

University Interscholastic League Steroid Agreement

Parent and Student Agreement/Acknowledgement – Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or increase in muscle bulk or strength through the use of steroid by a person in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

Student and Parent Acknowledgment and Agreement

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uiltexas.org. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student (Print)_____**Grade (9-12)** _____**Student Signature:** _____**Date:**_____

Parent/Guardian Print):_____**Relationship:**_____**Signature:**_____**Date:**_____

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, ie. HIPAA and FERPA.

_____ **Parent / legal guardian signature**

_____ **Student signature**

_____ **Date**

By signing below you are stating that all information on this form is correct. Falsifying or forging any information can make the student-athlete ineligible for athletics

_____ **Parent Signature**

_____ **Date**

****HIGH SCHOOL STUDENTS INCLUDING THOSE GOING IN TO THE 9TH GRADE****

Return your completed form to your campus Athletic Training Room.

**** DO NOT GIVE ANY FORMS TO COACH OR NURSE****

**** INTERMEDIATE STUDENTS ONLY****

Middle School Students (going to the 7th and 8th grades only) return all completed forms to the **HEAD COACH**

If you have any questions about this form or where to turn this in, **including turn in locations and times**…Please call the **PASADENA ISD** Athletic Office at 713-740-0840 or your campus athletic training room.

Dobie HS: 713-740-0370 **Memorial HS**: 713-740-0390 **Pasadena HS:** 713-740-0310
Sam Rayburn: 713-740-0330 **South Houston:** 713-740-0350