2023 - 2024 Northside ISD Medical History

X Student ID # _____

This form may ONLY be returned to a HS Staff Athletic Trainer or MS Head Coach when completed.
This form must be on file prior to participation in any practice, scrimmage or contest before, during or after school.

Student Name LAST	Student Name FIRST	Grade 23 - 24 school year	Date of Birth

Student Address (Street, City, Zip Code)	Student Phone	Age	Sex

In case of Emergency contact:

Name	Relationship	Phone	Cell Phone

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 to which you do not know the answer

		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? Date of the 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 pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do 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, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), 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?	☐	☐
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 below)		
	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 (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9	Have you ever been dizzy during or after exercise?	☐	☐
10	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11	Have you ever become ill from exercising in the heat?	☐	☐
12	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have Asthma?	☐	☐
	*** If yes, complete both sides of the Asthma Action Form**		
	Do you have an inhaler?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
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 other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below.		

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

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 diseases?	☐	☐
	Females only		
19	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?	_____	

☐ **An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain and ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. 2019 HB 76**
I understand it is the responsibility of my family to schedule and pay for an ECG.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (Attach additional sheet if necessary)

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'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

X **Student Signature:** _____ X **Parent/Guardian Signature:** _____ **Date:**_____

Any yes answer to questions, 1, 2, 3, 4, 5 or 6, may require further medical evaluation, which may include a physical exam. The written clearance from a Physician, Physician Assistant, Chiropractor, or Nurse Practitioner is required before any participation in UIL practices, games or matches.

For School Use only: ***Athletic Trainers Signature:*** _____ ***Date*** _____

PRE-PARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Physical Examination must be performed and signed on or after April 1, 2023 to be valid for participation in sports for the 23 – 24 school year Student's Name _____ Sex _____Age _____ Date of Birth _____

Height_____ Weight_____ % Body fat (optional) _____ Pulse _____ BP_____/_____ (_____/_____, _____/_____)

Brachial blood pressure while sitting

Vision R 20/_____ L 20/_____ Corrected: ☐Y ☐N Pupils: ☐Equal ☐Unequal

This **Physical Examination Form** must be completed prior to Middle School or High School athletic participation.

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearances			
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			
Neck			
Back			
Shoulder/Arm			
Elbow/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

☐Cleared

☐Cleared after completing evaluation/rehabilitation for: _____

_____

☐Not cleared for:_____ Reason: _____

Recommendations:_____ _____

Physical Examination must be performed and signed on or after April 1, 2023 to be valid for participation in sports for the 23 – 24 school year.

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.

Name (print/type) _____ Date of Examination:_____

Address:_____

Phone Number:_____

Signature:_____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL. Updated March 06, 2023