

# 2016-2017 Conroe Independent School District Pre-Participation Form

\*\*CISD will not accept paperwork dated prior to April 15, 2016\*\*

## BACKGROUND INFORMATION – REQUIRED

Student's Last Name / Student's First Name / Student's Middle Name \_\_\_\_\_

Sex \_\_\_\_\_

Age \_\_\_\_\_

2016-17 grade:  7  8  9  10  11  12

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

Student ID Number \_\_\_\_\_

2016-17 School:

- |  |  |  |                                       |                                     |  |
|--|--|--|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Knox          | <input type="checkbox"/> McCullough          | <input type="checkbox"/> Moorhead        | <input type="checkbox"/> Peet         | <input type="checkbox"/> Washington | <input type="checkbox"/> York            |
| <input type="checkbox"/> Irons         | <input type="checkbox"/> Caney Creek         | <input type="checkbox"/> Conroe          | <input type="checkbox"/> Conroe - 9th | <input type="checkbox"/> Oak Ridge  | <input type="checkbox"/> Oak Ridge - 9th |
| <input type="checkbox"/> The Woodlands | <input type="checkbox"/> The Woodlands - 9th | <input type="checkbox"/> TW College Park |                                       |                                     |  |

Parent/Guardian 1 Name (include last name) \_\_\_\_\_

Parent/Guardian 1 - Cell Phone \_\_\_\_\_

Parent/Guardian 1 – Work Phone \_\_\_\_\_

Parent/Guardian 2 Name (include last name) \_\_\_\_\_

Parent/Guardian 2 - Cell Phone \_\_\_\_\_

Parent/Guardian 2 – Work Phone \_\_\_\_\_

Student's - Home Phone \_\_\_\_\_

Student's Home Address (street, city, zip) \_\_\_\_\_

## EMERGENCY INFORMATION – FILL IN ALL BLANKS – REQUIRED

Name of Alternate Contact In Case of Emergency \_\_\_\_\_

Relation to Student \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Allergies to medication or other (please list): \_\_\_\_\_

Any medications taken regularly (please list): \_\_\_\_\_

Any medical concerns that should be noted: \_\_\_\_\_

## INSURANCE INFORMATION – REQUIRED \*\*If none, please write "none" - signature still required\*\*

Name of Insured: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ Insurance Company Phone #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

### Medical History

Does your child have a previous history of:

Yes    No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Bone/joint injury or disease? .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck injury? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Being unconscious/knocked out? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures/convulsion? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent headaches? .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding/blood disorders? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat illness? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies (seasonal, insects)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies (medications)? .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Viral infection (mono)? .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye/vision problems? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Missing/non-functioning limbs .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma? .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional disturbance? .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Take medication? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Had surgery in the past year? .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Currently under physicians care? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Wearing contacts/glasses? .....        | <input type="checkbox"/> | <input type="checkbox"/> |

Conroe ISD provides **secondary** accidental injury insurance coverage for students who participate in UIL sanctioned activities for grades 7-12. The parent/guardian's insurance policy is always the primary carrier with the Conroe ISD insurance coverage as a secondary carrier. This policy pays per a schedule of benefits and covers injury, not illness. **Each injury will include a deductible.** This policy is provided for UIL participants at no cost to the parent/guardian. It is the **responsibility of the parent/guardian to file any and all insurance claims within 180 days of the injury.** Injury claim forms are available in each school's front office or through each feeder zone's high school Licensed Athletic Trainer.

**I acknowledge that there is no Conroe ISD Athletic insurance to purchase. I have read and understand the above paragraph.**

Parent/Guardian sign (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

### CONSENT – REQUIRED

I 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 school assumes any responsibility in case an accident occurs. If, in the judgement of any representatives of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; and 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 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.

Parent/Guardian sign (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

Student sign (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

**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.**

## ACKNOWLEDGEMENT OF RULES – REQUIRED

**Attention School Authorities:** *This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

16-17 School: \_\_\_\_\_

### Parent or Guardian's Permit

I 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.

Furthermore, as a condition of participation and for the purpose of ensuring compliance with University Interscholastic League (UIL) rules, I consent to the disclosure of personally identifiable information, including information that may be subject to the Family Educational Rights and Privacy Act (FERPA), regarding the above named student between and among the following: the high school or middle school where the student currently attends or had attended; any school the student transfers to; the relevant District Executive Committee and the UIL. I further understand that all information relevant to the student's UIL eligibility and compliance with other UIL rules may be discussed and considered in a public forum. I acknowledge that revocation of this consent must be in writing and delivered to the student's school and the UIL.

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.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

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 judgement of any representatives of the school, the above student needs 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 to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and 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 provided the UIL Parent Information Manual regarding health and safety issues including concussions 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.

**The UIL Parent Information Manual is located at [www.uil-texas.org/files/athletics/manuals/parent-information-manual.pdf](http://www.uil-texas.org/files/athletics/manuals/parent-information-manual.pdf).**

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

### School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (*exception: See Section 1209 of the Constitution and Contest Rules*).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in-school-day athletic period in baseball, basketball, football, soccer, softball, or volleyball.
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

### General Eligibility Rules

**According to UIL standards, students could be eligible to represent their school in interscholastic activities if they:**

- are not 19 years of age or older on or before September 1 of the current scholastic year. (*See Section 446 of the Constitution and Contest Rules for exception*).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for 15 calendar days immediately preceding a varsity contest.
- are full-time students in the participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (*Parent residence applies to varsity athletic eligibility only.*)  
When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (*see Section 442 of the Constitution and Contest Rules*).
- have observed all provisions of the Awards Rule.
- have not been recruited. (*Does not apply to college recruiting as permitted by rule.*)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, basketball, football, soccer, softball, and volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (*tangible or intangible property or service including anything that is usable, wearable, salable or consumable*) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

**I have read the regulations cited above and agree to follow the rules.**

**To the parent:** *Check any activity in which this student is allowed to participate:*

- Baseball       Basketball       Cross Country       Football       Golf       Softball       Soccer  
 Swimming & Diving       Tennis       Team Tennis       Track & Field       Volleyball       Wrestling  
 Other – please list: \_\_\_\_\_

**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.**

Street address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home area code and telephone: \_\_\_\_\_ Business telephone: \_\_\_\_\_

Parent/Guardian sign (required): \_\_\_\_\_  Student sign (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

# Concussion Acknowledgement Form – REQUIRED

Name of Student: \_\_\_\_\_

**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 rest. Also avoid external stimulation such as watching television, music, 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 38.159.

X \_\_\_\_\_  
*Parent/Guardian signature (required)*

\_\_\_\_\_  
*Date/Year*

X \_\_\_\_\_  
*Student signature (required)*

\_\_\_\_\_  
*Date/Year*

# Sudden Cardiac Arrest Awareness Form – REQUIRED

Revised February 2015

Name of Student: \_\_\_\_\_

## What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

## What causes Sudden Cardiac Arrest?

- **Conditions present at birth**
  - **Inherited** (*passed on from parents/relatives*) **conditions of the heart muscle:**
    - **Hypertrophic Cardiomyopathy** – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Arrhythmogenic Right Ventricular Cardiomyopathy** – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
    - **Marfan Syndrome** – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.
  - **Inherited conditions of the electrical system:**
    - **Long QT Syndrome** – abnormality in the ion channels (electrical system) of the heart.
    - **Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome** – other types of electrical abnormalities that are rare but run in families.
  - **Non-Inherited** (*not passed on from the family, but still present at birth*) **conditions:**
    - **Coronary Artery Abnormalities** – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Aortic valve abnormalities** – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
    - **Non-compaction Cardiomyopathy** – a condition where the heart muscle does not develop normally.
    - **Wolff-Parkinson-White Syndrome** – an extra conducting fiber is present in the heart’s electrical system and can increase the risk of arrhythmias.

- **Conditions not present at birth but acquired later in life:**
  - **Comotio Cordis** – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
  - **Myocarditis** – infection/inflammation of the heart, usually caused by a virus.
  - **Recreational/Performance-Enhancing drug use.**
- **Idiopathic:** Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

## What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

*ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.*

## What is the treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- CALL 911
- Begin CPR
- Use an Automated External Defibrillator (AED)

## What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 14 important cardiac elements.
- The UIL Pre-Participation Physical Evaluation – Medical History form includes *all* 14 of these important cardiac elements and is mandatory annually.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

## Where can one find information on additional screening?

The cardiac section on the UIL Health and Safety website ([uiltexas.org](http://uiltexas.org)).

X \_\_\_\_\_  
Parent/Guardian signature (required)

\_\_\_\_\_  
Date/Year

X \_\_\_\_\_  
Parent/Guardian name (print)

X \_\_\_\_\_  
Student signature (required)

\_\_\_\_\_  
Date/Year

X \_\_\_\_\_  
Student name (print)

## Anabolic Steroid Use and Random Steroid Testing – REQUIRED

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is 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 Acknowledgement 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](http://www.uiltexas.org). I understand and agree that the results 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 name (print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

Student signature (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

### Parent/Guardian Certification and Acknowledgement

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child 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 student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at [www.uiltexas.org](http://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 my student to penalties as determined by UIL.

Name (print): \_\_\_\_\_ Signature (required): \_\_\_\_\_ Date/Year: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

## MEDICATION PERMISSION – OPTIONAL

*Note: Junior high school athletes will not receive any medication*

Athletic Trainers, Licensed by the State of Texas (LAT) and employed by the Conroe ISD, are hereby given my acknowledgment and consent to administer nonprescription over-the-counter medication to my child. A complete list of over-the-counter medications is available from each campus. I also give consent to administer prescription medication when prescribed by my child's physician and accompanied by the CISD Medication Permission Form. The original prescription label must be on the medication container.

Parent/Guardian sign (optional): \_\_\_\_\_ Date/Year: \_\_\_\_\_

**Conroe Independent School District**  
3205 West Davis Conroe, Texas 77304-2098

**Parental Acknowledgement of Use of Participant's Personal Vehicle**

**Attention: This form is to be completed only if your son/daughter will need permission to travel in a private (non-Conroe ISD) vehicle for practice or competition.**

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_ Activity: \_\_\_\_\_

**In-District Transportation**

I understand that the Conroe Independent School District (CISD) will not provide transportation to in-District off-campus school-approved facilities for the purpose of practicing or competition for the named activity. I understand that as a condition of participation in the activity of:

\_\_\_\_\_, my child must obtain his or her own transportation to the in-District off-campus school-approved facility to practice or compete.

**Out-of-District Transportation**

I further understand that the Conroe Independent School District (CISD) will provide transportation for all out-of-district competitions associated with the above activity. I understand that I may request that my child not be transported to and from competitions for the above named activity using District transportation by making a written request to my child's coach. I understand, however, that the coach has the authority to grant or deny that request. If the coach denies the request, my child must arrive at and depart from the competition on District transportation.

It is understood that when my child is transported by other than District-provided transportation to either practice or competition in the above activity, CISD will not assume any responsibility in case of an accident, injury, or other loss associated with the transportation. I hereby release CISD, its trustees, officers, employees, and agents from any and all liability and any responsibility in connection with such trips, and I agree to indemnify and hold harmless all said parties from claims hereafter made or asserted on behalf of the above named student or asserted by or on behalf of any other person where such claims arise out of an accident, injury, or loss associated with the transportation.

**I, the undersigned, have read this Parental Acknowledgment and understand all the terms.  
I have executed it voluntarily with the full knowledge of its significance.**

\_\_\_\_\_  
*Parent/Guardian signature*



Student's Name \_\_\_\_\_ Primary Sport \_\_\_\_\_ 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. 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.

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.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. Have you had a medical illness or injury since your last check up or sports physical?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed out during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member been diagnosed with enlarged heart, (dilatated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a head injury or concussion?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____ When was the last concussion? _____  |                          |                          |
| How severe was each one? (Explain) _____   |                          |                          |
| Have you ever had a seizure?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you missing any paired organs?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you under a doctor's care?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever become ill from exercising in the heat?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had any problems with your eyes or vision?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever gotten unexpectedly short of breath with exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a sprain, strain, or swelling after injury?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below.  |                          |                          |
| <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"/> Back <input type="checkbox"/> Wrist <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"/> Upper Arm <input type="checkbox"/> Foot                  |                          |                          |
| 16. Do you want to weigh more or less than you do now?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you feel stressed out?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?.....  | <input type="checkbox"/> | <input type="checkbox"/> |

**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 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): \_\_\_\_\_

**MEDICAL EXAMINER SECTION**

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 in the left column. \*CISD 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 position			
Heart – Auscultation			
Standing position			
Heart – Lower			
Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE** \* Station-based examination only

Cleared  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 Not cleared for: \_\_\_\_\_  
 Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

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: \_\_\_\_\_

**This form and packet, in its entirety, must be on file prior to participation in any practice, scrimmage or contest before, during, or after school.**

**For school use only** This medical history form was reviewed by: \_\_\_\_\_  
 Printed name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_