Revised 2/19/18

Eanes ISD Pre-Participation Physical Evaluation Form

Last Name	First Name	MI	Student ID	Grade	Date of Birth	Sex	Sports (List All Participating In)

Street Address (No P.O. Boxes)	City Zip	Home Phone

Female Guardian's Name	Employer	Cell Phone	Work Phone	Relationship to Student
Male Guardian's Name	Employer	Cell Phone	Work Phone	Relationship to Student
Secondary Emergency Contact Name		Cell Phone	Home Phone	Relationship to Student

EANES ISD POLICY REQUIRES THAT EACH ATHLETE HAVE ANNUAL PHYSICAL DATED AFTER APRIL 30, 2018

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL, INCLUDING AN ATHLETIC PERIOD.

	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?	☐	☐
3. Have you ever had prior testing for the heart ordered by a physician?	☐	☐
• What age? _____		
• What was the diagnosis? _____		
• Have you ever passed out 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, (dilated cardiomyopathy) hypertrophic cardiomyopathy, long QT syndrome, or abnormal heart rhythm)?	☐	☐
• Have you had a severe viral infection (ex: 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 in Responses section		
• 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 currently under a doctor's care for a specific illness, injury or medical condition?	☐	☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?	☐	☐
8. Do you have any allergies (ex: pollen, medicine, food, stinging insects)?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems (ex: itching, rashes, acne, warts fungus, or blisters)?	☐	☐

	YES	NO
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐
13. Have you ever been unexpectedly short of breath with exercise?	☐	☐
Have you ever been diagnosed with asthma?	☐	☐
Within the past year, have you experienced an asthma attack?	☐	☐
Are you prescribed an inhaler?	☐	☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (ex: knee brace, special neck roll, foot orthotics, retainer on 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(es) below and explain in Responses section.		

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

16. Are you unsatisfied with your current weight?	☐	☐
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 disease?	☐	☐
19. Do you have any other medical conditions not previously mentioned (ex: diabetes, thyroid disease, immune disorders, bleeding disorder, etc)?	☐	☐
MALES ONLY		
20. Do you have two testicles?	☐	☐
21. Do you have any testicular swelling or masses?	☐	☐
FEMALES ONLY		
22. 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? _____		

RESPONSES (explain yes answers; use another sheet if necessary)

_____

_____

CIRCLE ALL SPORTS IN WHICH THE STUDENT IS ALLOWED TO PARTICIPATE:

Football Volleyball Baseball Wrestling Basketball Golf Soccer Softball Tennis Cross Country Track & Field Swimming & Diving Cheer

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. Our signatures indicate we have read, understand, and agree with the entire document including the Medical History, Steroid Agreement, UIL Rules, UIL Parent Information Manual, Concussion Information, Insurance Information, and Parent Permit.

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

Doctor: _____	School Official: _____
Signature	*Signature*

Eanes ISD Pre-Participation Physical Evaluation Form

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ Pulse _____

BMI % _____ % Body fat (optional) _____

BP	/	/	/	*brachial blood pressure while sitting*
%	/	/	/	

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

NORMAL		ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
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			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Marfan's stigmata (arachnodactyly, pectus, excavatum, joint hypermobility, scoliosis)			

*station based only

CLEARANCE

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for: _____

Reason: _____

Recommendations: _____

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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: _____

Signature: _____ **SIGNATURE ALSO REQUIRED BELOW MEDICAL HISTORY ON FRONT OF FORM**

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.