PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

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In case of energency, contact: Relationship Phone (II) (W)	Grade School								
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	Have you had any problems with your eyes or vision?								

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 participation, 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

Student Signature:

Parent/Guardian Signature:

Date:

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

For School Use Only:

This Medical History Form was reviewed by: Printed Name

Date

Signature

PREPARTICIPA	TION PHYSICAL	EVALUATION PHYSICAL E	XAMINATION	Student ID_		
Student's Name		Sex	Age	Date of Birth		<u>.</u>
Height	Weight	% Body fat (optional)	Pulse	BP	/ (brachial bloc	/,/) d pressure while sitting
Vision: R 20/	L 20/	Corrected: D Y	🗆 N	Pupils:	🗖 Equal	□ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It *must* be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. * *Local district policy may require an annual physical exam.*

	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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly,			
pectus excavatum, joint			
hypermobility, scoliosis)			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
*station-based examination only			
CLEARANCE			
		ТМ	
□ Cleared after completing evaluation	on/rehabilitatio	n for:	
□ Not cleared for:		Reason:	
Recommendations:			
The following information must be fil	lad in and sign	ned by either a Physician, a Physician Assistant licensed by a Stat	a Roard of
	-		
-		recognized as an Advanced Practice Nurse by the Board of Nurse	e Examiners,
or a Doctor of Chiropractic. Examination	ation forms siz	gned by any other health care practitioner, will not be accepted.	
Name (print/type)		Date of Examination:	
Phone Number:			

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.

Signature: _