CHRISTUS Health®

Sports Physicals

For ALL CURRENT 8th and 10th graders

Saturday, May 1st 9 AM

Meet at the High School at 8:30 am

Health Park Plaza

1327 Troup HWY Tyler, TX

Come see your coach or visit the Athletic Training Room to pick up a packet for more information

Packet must be completely filled out and turned in by Tuesday April 27th to the Athletic Training Room

Transportation will be provided from the High School

CHRISTUS
TRINITY MOTHER FRANCES
Health System

Dear Parent/Guardian:

Screening evaluations for athletes participating in high school sports during the 2021-'22 academic year will be performed by physicians and athletic trainers from **CHRISTUS Trinity Mother Frances Sports Medicine Program,** on **Saturday, May 1, 2021** at the CHRISTUS Orthopedics & Sports Medicine Building located at 1327 Troup Hwy in Tyler.

To assist us in providing the best service for your child, please review the following:

(1) Waiver and Release of Liability Form
(2) Emergency and Insurance Information Form
(3) Consent to Treatment Form
(4) Privacy Form; and
(5) U.I.L. – Concussion Acknowledgement Form
(6) U.I.L. – Sudden Cardiac Arrest Awareness Form
(7) U.I.L. - Medical History Questionnaire

(Please read and sign the forms in the designated areas. It is critical that all of this paperwork is completed and presented at the time of the evaluation.)

This is a screening evaluation, which **DOES NOT** replace the annual physical examination performed by your child's primary care physician. The evaluation is designed to help screen athletes who may be more likely to suffer an injury or have a medical problem due to participation in sports. **We do not perform vision tests, hernia checks, or testicular exams.** Such exams should be performed routinely during a physical exam or an eye exam. Any athlete with vision or testicular abnormalities should be examined by a qualified physician who can advise the athlete and his/her parents or guardians concerning precautions necessary for sports participation.

If your child has a chronic medical condition or requires prescribed medications on a daily basis, his/her primary care physician should perform a complete physical and evaluation for participation in sports.

If a problem is detected with your child during this screening, he/she will be referred to the primary care physician and possibly a specialist.

Thank you for your assistance.

Sincerely,

Jim Rapp, MS, ATC/L
Director, Sports Medicine
CHRISTUS Trinity Mother Frances Health System

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or 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?	☐	☐
	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 activities 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 your 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?	☐	☐
	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 activity 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:

☐ Head	☐ Elbow	☐ Hip
☐ 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?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

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? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

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, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____

_____

_____

_____

It is understood that even though protective equipment is worn by athletes, 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 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 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 _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

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

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)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ 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.

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

Address: _____

Phone Number: _____

Signature: _____

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.

Waiver and Release of Liability Form

Printed Name of Student _____ Date _____

Printed Name of Parent/Guardian _____ Date _____

The parent or guardian of every participant in the UIL student screening process must read and sign this waiver form prior to participation.

I am the parent or guardian of the minor listed above (or I am the Student listed above). I understand and agree that this physical screening meets the UIL minimum requirements for a student athlete to participate in school athletic competition.

I agree and understand that CHRISTUS Trinity Mother Frances Health System, and its affiliates, including but not limited to, CHRISTUS Mother Frances Hospital Regional Health Care Center, and CHRISTUS Trinity Clinic and all physicians, directors, corporate member, religious sponsors, officers, employees, and agents (collectively hereinafter referred to as "CHRISTUS Trinity Mother Frances") conducting screening SHALL NOT ASSUME ANY RESPONSIBILITY or LIABILITY in case my child is (or MY children are or I am) injured during any school athletic practice or competition. Furthermore, I specifically agree and understand that there may be severe risks (including death) associated with my child's (children's/my) participation in school athletics and related activities. I expressly agree and understand that these physical screenings DO NOT TAKE THE PLACE OF a comprehensive physical examination which is available to my child (children/me). I KNOWINGLY, WILLINGLY, AND VOLUNTARILY ACCEPT THE RISKS OF HAVING MY CHILD (CHILDREN) UNDERGO (OR IN MY UNDERGOING) only the UIL minimum screening requirements.

Additionally, I agree and understand that CHRISTUS Trinity Mother Frances and all physicians who are performing the physical screenings SHALL NOT BE HELD LIABLE BY ME (OR US) for any claims, demands, suits and/or expenses arising out of or related to the physical screening performed on my child (children/me) to the fullest extent permitted by law.

I (we) hereby acknowledge that the health care practitioner is administering this pre-participation evaluation or medical screening without compensation and without expectation of compensation and further acknowledge the limitations on recovery of damages from the health care practitioner in connection with the pre-participation physical examination or medical screening being performed.

I (we) hereby KNOWINGLY AND FREELY RELEASE AND WAIVE ANY AND ALL CLAIMS, OF ANY NATURE WHATSOEVER, against CHRISTUS Trinity Mother Frances as a result of any injury or illness arising out of or relating (in any way) to the screening and/or my child (children's/my) participation in school athletic practice and/or competition.

Parent/Guardian signature _____ Student's signature (age 18 or above) _____

STUDENT ATHLETE EMERGENCY and INSURANCE INFORMATION

Student Name: _____ Date of Birth: ____/____/____

Parent/Legal Guardian Name: _____ Date of Birth: ____/____/____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street City Zip Code

Name of Emergency Contact Person: _____

Relationship: _____ Home Phone: _____

Work Phone: _____

The following information is very important to have on file in case of emergency situations. Please fill in the information to the best of your abilities. Please list any insurance coverage, including Champus, Medicare, Medicaid, accident policies, HMO's, etc. If you do not have insurance coverage, please check the "No Insurance" box.

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____
Street

_____
City State Zip Code

NAME OF INSURED: _____
Last First M.I.

RELATIONSHIP: _____ PHONE: _____

INSURED SSN: ____-____-____ FAMILY PHYSICIAN: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Revised 02/2004

STUDENT ATHLETE PRIVACY FORM
Authorization for
Disclosure of Protected Health Information

I, _____, parent or guardian of _____ (the "student athlete"), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel represent CHRISTUS Trinity Mother Frances Health System's Sports Medicine to release information regarding the student athlete's protected health information and related information regarding any injury or illness during the student athlete's training for and participation in athletics at _____ School (the "School"). This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of _____ College and the _____ School District.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete's protected health information is a condition for the student athlete's participation in interscholastic sports at the School. I understand that the student athlete's protected health information is protected under federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the School's athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

_____ _____

Print Student Athlete Name Signature of Parent/Legal Guardian

_____

Date

NOTICE OF PRIVACY PRACTICES

By signing above I acknowledge that I have received or have been offered a copy of CHRISTUS Trinity Mother Frances Health System's Notice of Privacy Practices.

CHRISTUS Orthopedic & Sports Medicine Institute
Sport Injury Evaluation Consent

I consent for a licensed Athletic Trainers from CHRISTUS Trinity Mother Frances Medical Center to provide athletic training services within the Athletic Trainer's scope of license to _____ (Athlete). I am the Athlete's (circle one) parent / guardian / other: _____. Athletic Training services include administering first aid for athletic injuries, providing initial treatment and management of these injuries, and assessing athletic injuries at the request of the Athlete, the Athlete's coach, or the Athlete's parent/guardian. This consent is given voluntarily and is not a requirement for the Athlete to participate in District sports programs.

The Athletic Trainers will perform only those procedures that are within his/her training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. A written report of any athletic injury assessment for the Athlete will be confidentially maintained and stored in a secure manner that allows access to authorized personnel only.

The Athletic Trainers is employed by CHRISTUS Trinity Mother Frances Medical Center and is not employed or under the direction or control of _____ Independent School District.

I authorize the Athletic Trainers who provides services to the Athlete to disclose information about the Athlete's injury assessments and post-injury status, to the involved coaching staff, any treating health care provider or consulting concussion management specialist. I will not be charged for the above listed athletic training services.

If the Athlete is in need of further treatment by a physician or other health care providers, including rehabilitation services for the injury, he or she should see the physician or provider of his/her choice. Although the Athletic Trainers is affiliated with CHRISTUS Trinity Mother Frances, there is no obligation to use a CHRISTUS Trinity Mother Frances facility or affiliated provider. Prior to the performance of any services under this Agreement, CTMF will instruct the Athletic Trainers, if asked to recommend a health care provider, to affirmatively inform the requester that he or she is free to choose any provider, regardless of location or affiliation. Injured athletes who have been evaluated or treated by a physician must submit written clearance from that physician to the Athletic Trainers [heal coach or] prior to the athlete being permitted to resume activity.

If the Athlete has been removed from play because of a suspected injury or concussion, the Athlete will not be permitted to return to play until the Athlete is evaluated by a health care provider, receives medical clearance and written authorization to return to play from that provider. This Consent will remain in effect for one sports season beginning with the date set forth below.

Student Athlete's Name: _____

_____

Signature of Athlete's parent / guardian / other: _____ (circle one)

Date: _____