TEXAS ASSOCIATION OF PRIVATE AND PAROCHIAL SCHOOLS

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION

STUDENT'S NAME _____ SPORT(S):_____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % OF BODY FAT:_____

PULSE: _____ BLOOD PRESSURE: ___/___ (___/___,___/___)

VISION R 20/_____L 20/_____CORRECTED: Y N Pupils: EQUAL_____UNEQUAL _____

In keeping with the requirements of the Texas Association of Private and Parochial School, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation **each** year of high school.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
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	NORMAL	ABNORMAL FINDINGS	INITIALS*
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: _____

_____

Provider Name: _____Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

PREPARTICIPATION PHYSICAL EVALUATION
MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed annually by parent (or guardian) and student in order for the student to participate in **TAPPS** 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.

STUDENT NAME (PRINT):		
GENDER:	AGE:	DATE OF BIRTH:
HOME ADDRESS:		
HOME PHONE:	PARENT CELL PHONE:	
SCHOOL:	GRADE LEVEL:	
PERSONAL PHYSICIAN:		
PHYSICIAN PHONE:		
In case of emergency contact:		
NAME:	RELATIONSHIP:	
HOME PHONE:	CELL PHONE:	

Explain any "**YES**" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "**YES**" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	YES	NO
1. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
3. Have you ever had surgery?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
5. Have you ever had chest pain during or after exercise?	☐	☐
6. Do you get tired more quickly than your friends during exercise?	☐	☐
7. Have you ever experienced racing of your heart or skipped heartbeats?	☐	☐
8. Have you ever had high blood pressure?	☐	☐
9. Have you ever had high cholesterol?	☐	☐
10. Have you ever been told you have a heart murmur?	☐	☐
11. Has any family member or relative died of heart problems before age 50?	☐	☐
12. Has any family member or relative died of sudden unexpected death before age 50?	☐	☐
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	☐	☐
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	☐	☐
15. Has any family member been diagnosed with Long QT Syndrome?	☐	☐
16. Has any family member been diagnosed with ion channelpathy (Brugada syndrome, etc.)?	☐	☐
17. Has any family member been diagnosed with Marfan's syndrome?	☐	☐
18. Have you had a severe viral infections (myocarditis, mononucleosis, etc.) in the past year?	☐	☐
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
20. Have you ever had a head injury or concussion?	☐	☐
21. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
22. Have you ever experienced a seizure?	☐	☐
23. Have you ever had numbness in your arms, hands, legs or feet?	☐	☐
24. Have you ever had a stinger, burner or pinched nerve?	☐	☐
25. Are you missing any paired organs?	☐	☐
26. Are you presently under a doctor's care?	☐	☐
27. Are you currently taking any prescription or nonprescription medications or inhalers?	☐	☐
28. Do you have any allergies?	☐	☐
29. Have you ever been dizzy before or during exercise?	☐	☐
30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	☐	☐
31. Have you ever become ill after exercising or working in the heat?	☐	☐

	YES	NO
32. Have you ever had any problems with your eyes or vision?	☐	☐
33. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
34. Do you have asthma?	☐	☐
35. Do you have seasonal allergies that require medical treatment?	☐	☐
36. Do you use any special protective or corrective equipment?	☐	☐
37. Have you ever had a sprain, strain or swelling after injury?	☐	☐
38. Have you ever broken or fractured any bones?	☐	☐
39. Have you ever dislocated any joints?	☐	☐
40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, please check the appropriate box and explain on separate sheet of paper.

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

41. Do you want to weigh more or less than you do now?	☐	☐
42. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities?	☐	☐
43. Do you feel stressed out?	☐	☐
44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	☐	☐

Females Only

45. When was your first menstrual period?	_____
46. When was your most recent menstrual period?	_____
47. How much time elapses from the start of one period to the start of another?	_____days
48. How many periods have you had in the last year?	_____
49. What was the longest time between period in the last year?	_____days

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of accident still remains. Neither the **Texas Association of Private and Parochial Schools**, 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 illness, 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, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, in 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 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 and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.

STUDENT SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN NAME (PRINT): _____

PARENT SIGNATURE: _____ DATE: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____

CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way a student's brain normally functions
- Can occur during practice or contests in any sport
- Can occur in activities both associated and not associated with the school
- Can occur even if the student has not lost consciousness
- Can be serious even if a student has just been "dinged" or had their "bell rung"

Are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, one or more of the following symptoms may become apparent. The student may not "feel right" soon after, a few days after or even weeks after the injury event.

Headache	"Pressure" in the head	Nausea	Vomiting
Balance problems	Dizziness	Blurry Vision	Double Vision
Sensitivity to Light	Sensitivity to Noise	Confusion	Memory Problems
Difficulty paying attention	Feeling sluggish, hazy, foggy or groggy		

If you have concerns regarding any of the above symptoms, your doctor should be consulted for further information and/or examination. Your physician or medical professional can best determine your student's physical condition and ability to participate in athletics.

What should students do if they believe that they or someone else may have a concussion?

- Students should immediately notify their coach or school personnel.
- Student should be examined by appropriate medical personnel of the parent's choosing. The medical provider should be trained in the diagnosis and treatment of concussions
- If no concussion is diagnosed, the student shall be cleared to return to athletic participation.
- If a concussion is diagnosed, the school protocol for return to play from a concussion shall be enacted. Under no circumstances shall the student be allowed to return to practice or play without the approval of a licensed medical provider trained in the treatment of concussions.

I have reviewed the above material. I understand the symptoms and warning signs of CONCUSSIONS. Additional information is available on the Health and Safety page at www.tapps.biz. All concussions should be reported to the school as soon as possible. Previous concussions should be reported on the Medical History form to allow the medical practitioner the best information possible when conducting the annual physical examination.

Parent Signature / Date: _____

Student Signature / Date: _____

CONCUSSIONS – Don't hide it. Report it. Take time to recover.

SUDDEN CARDIAC ARREST

What is Sudden Cardiac Arrest (SCA)?
Sudden Cardiac Arrest is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is not a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction of the heart's electrical system, causing the heart to stop beating.

How common is Sudden Cardiac Arrest?
While studies differ in the actual rate of occurrence, the American Heart Association information indicates that there are approximately 300,000 SCA events outside hospitals each year in the United States. About 2000 patients under the age of 25 die of SCA each year. Studies now being performed in Texas and other states indicate the occurrence rate for high school age athletes may be greater than this figure.

Are there warning signs?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

Dizziness	Fatigue	Lightheadedness
Extreme tiredness	Shortness of breath	Nausea
Difficulty breathing	Vomiting	Racing or fluttering heartbeat
Chest Pains	Syncope (fainting)	

These symptoms can be confusing and unclear in athletes. Often people confuse these warning signs as physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

For this reason these symptoms are included on the Medical History form provided by TAPPS and required for each student prior to participation in athletic events each year. As parents and student athletes, your truthful answers to these simple questions will assist your medical practitioner when performing the annual physical examination.

What are the risks of participation and playing with these symptoms?
Continued participation brings with it increased risk. This includes playing in practices and games. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just minutes. Most people who experience a SCA die from the event.

While TAPPS does not mandate Cardiac Screening prior to participation, TAPPS and the TAPPS member schools recognize the importance of our students' health and highly recommend discussing screening options with your healthcare provider. Any student who shows signs of SCA should be removed by the parents from play. This includes all athletic activity, practices or contests. Before returning to play, the student should be examined and receive clearance by a licensed health care professional of the parents' choosing.

I have reviewed the above material. I understand the symptoms and warning signs of SCA. Additional information is available on the Health and Safety page at www.tapps.biz.

Parent Signature / Date: _____

Student Signature / Date: _____

PARENT AND STUDENT NOTIFICATION
STEROID USE AGREEMENT FORM

State law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.

State law requires that only a medical doctor may prescribe a steroid for a person.

State law provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person in good health is not a valid medical purpose.

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.

HEALTH CONSEQUENCES ASSOCIATED WITH ANABOLIC STEROIDS

(source: National Institute on Drug Abuse)
hhtp://www.nida.nih.gov/Infofacts/steroids.html

For boys and men – shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts, increased risk for prostate cancer.

For girls and women – growth of facial hair, male-pattern baldness, changes in or cessation of the menstrual cycle, enlargement of the clitoris, deepened voice.

For adolescents – growth halted prematurely through premature skeletal maturation and accelerated puberty changes. This means that adolescents risk remaining short for the remainder of their lives if they take anabolic steroids before the typical adolescent growth spurt.

For all ages – potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension which can promote heart attack and stroke; and acne. Available evidence may suggest that anabolic steroid abuse, particularly in high doses, promotes aggression that can manifest as fighting, physical and sexual abuse, and property crimes. Upon stopping anabolic steroids, some abusers may experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, headaches, muscle and joint pain and the strong desire to return to the use of anabolic steroids.

For Injectors – infections resulting from the use of shared needles or non-sterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

STUDENT CERTIFICATION

I have read the above information and agree that I will not use illegal anabolic steroids.

Student Signature_____Date_____

PARENT / GUARDIAN CERTIFICATION

I have read the above information and agree to my knowledge my student will not use illegal anabolic steroids.

Parent/Guardian Signature_____Date_____

TAPPS

CATHEDRAL
HIGH SCHOOL

1309 N. STANTON ST. | EL PASO, TX 79902-4121 | P: 915.532.3238 F: 915.533.8248 | WWW.CATHEDRAL-ELPASO.ORG

CATHEDRAL HIGH SCHOOL ATHLETICS

Rules and Responsibilities Form for Students/Teams Traveling

PLEASE READ CAREFULLY!

The following are rules and responsibilities set by Cathedral High School and the Athletic Program to ensure the utmost safety of all those traveling.

ALL RESPONSIBILITIES AND RULES OF CONDUCT FOR CATHEDRAL ATHLETES ARE TO BE OBEYED AT ALL TIMES.

Students:

1. Remember that you are representing Cathedral High School.
2. You must follow all rules set by Cathedral High School and your Coach/Sponsor
3. You must adhere to CURFEW. Curfew will be set by the Coach/Sponsor to ensure the location and safety of the student.
4. Rooms will be inspected at unpredictable times to ensure you are where you need to be.
5. Excellent behavior and attitude is expected at all times.
   *There will be **NO HAZING OF ANY KIND**
   ***NO CUTTING** or **DYING of HAIR**
   *At **NO** time is **ALCOHOL**, any **TOBACCO, VAPING** product or **ILLICIT DRUGS** allowed
   *At **NO** time should there be any **PORNOGRAPHIC literature**, or acts of any kind of immoral acts.
   ***RUDE** or **VULGAR** language, back talking, or any other type of **PROFANITY** will **NOT** be tolerated
   ***NO** fighting or abusive behavior
   ***PARENTS WILL OBEY AT ALL TIMES PROPER ETIQUET AT ALL TIMES OR WILL ADHERE TO ALL CONSQUENCES!!!**
6. All rules should be obeyed while on hotel or any other property
   ***Hotels** are free to impose any sanction they may deem necessary to maintain order, even to the point of the person or persons causing disturbances or damages.

Consequences For Breaking Any Rule:

1. Student will be sent home at parent's expense.
2. Parents will be responsible for payment of damages and or repairs
3. Students will be suspended or expelled from school/team depending on severity of incident.

USE THE BEST JUDGMENTABOUT THE DECISIONS YOU MAKE! REMEMBER TO BEHAVE LIKE A GENTLEMAN AND REMEMBER YOU ARE REPRESENTING, NOT ONLY CATHEDRAL HIGH SCHOOL, BUT ALSO YOUR CITY, FAMILY AND MOST OF ALL YOURSELF!

Carlos M. Puertas M.A/ Director of Athletics

I have read these rules and I promise to abide by them.

Student Signature: _____ **Date:** _____

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

ATHLETICS DEPARTMENT COPY

CATHEDRAL HIGH SCHOOL

CATHEDRAL HIGH SCHOOL

New Student ☐

Returning Student ☐

MEDICAL & EMERGENCY INFORMATION

Student's Full Name : _____ **DOB:** _____ **Grade Level :** _____

IN CASE OF AN EMERGENCY, CONTACT THE FOLLOWING PARENT/GUARDIAN:

Name : _____ Relationship To Student : _____

Day Phone : _____ Cell Phone : _____ Email Address : _____

IF THE PARENT/GUARDIAN CANNOT BE REACHED, CONTACT THE NEAREST RELATIVE OR FRIEND LISTED BELOW:

Name : _____ Relationship To Student : _____

Day Phone : _____ Cell Phone : _____ Email Address : _____

Family Physician : _____ **Phone :** _____

Preferred Hospital : _____ Insurance & Policy # : _____

***Chronic Medical Conditions :** _____ ***Medications :** _____ ***Allergies :** _____

*** (If Yes, Please Explain In Space Provided Below)**

Additional Information :

***School does not dispense any type of medication. If student requires medication, it must be brought from home, with written directions from the doctor and written consent from the parent to give the medication. (Forms available in the Attendance Office).**

Parents'/Guardians' Consent For Emergency Medical Treatment – MINOR CHILD

I/We _____, the undersigned Parent(s)/Guardian(s) of _____ do hereby authorize the authorities of CATHEDRAL HIGH SCHOOL to permit its designated representatives to give consent to a physician and/or emergency medical and/or emergency surgical treatment during school or after school hours while taking part in school sponsored activities, such as educational, social, and athletic events, provided such event or events have an authorized representative of the school present.

It is understood that the school or its representatives do not assume any financial responsibility for any expenses that might be incurred for said emergency treatment. It is further understood that school authorities will notify us as soon as possible following the emergency, but in no way is treatment to be delayed until we have been notified.

Signature : _____ Date : _____ Staff Member Initials : _____