PHYSICALS MUST BE COMPLETED AFTER APRIL 1, 2014

School Attending 2014-15

First Name

Last Name

McKinney Independent School District
UIL Physical Exam Form

Please Print

Student Name:_____
Last First M.I.

Circle Grade for 20014-15 School year: 7 8 9 10 11 12 Sport:_____

Sex:____ Age:____ Date of Birth____/____/___ Home Phone:_____ Student ID#_____

Home Address:_____
Street City State Zip Code

Parent/Guardian Information:

Mother's Name:_____ Father's Name:_____

Mother's Workplace:_____ Father's Workplace;_____

Work Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone:_____

E-Mail Address:_____ E-Mail Address:_____

Emergency Contact:

Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____

Personal Physician:_____ Phone:_____

PARENT OR GUARDIAN'S PERMIT

By my signature below, I do hereby acknowledge and agree as follows:

- I have been fully informed that participation of the above named student in University Interscholastic League(UIL) approved sports through McKinney Independent School District(MISD) is strictly voluntary and not required by the MISD. I acknowledge that my Student's participation is by his/her own choice and that my Student chooses to at his/her own risk. Further, I hereby give my consent for my Student to compete in UIL approved sports, and travel with the coach or other representative of the school on any trips.
- I understand that even though protective equipment is worn by my Student whenever needed, the possibility of an accident still remains. Neither the UIL nor the MISD assumes any responsibility in case an accident occurs.
- I, the undersigned, agree to be responsible for the safe return of all athletic equipment issued by the school to my Student.
- If, in the judgment of any representative of the MISD, my Student needs immediate care and treatment as a result of injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given to my Student by any physician, athletic trainer, nurse, hospital or school representative. I do, individually and on behalf of my Student hereby agree to indemnify hold harmless, release and discharge the MISD, its governing board, agents, employees, and officers, from any and all claims, demands, liabilities, actions, judgments, expenses (including attorneys' fees and costs of defense), and executions which may be made by reason of any injury to my Student (including, but not limited to, serious bodily injury or death), caused by any act, neglect, default, or omission of any person, firm, or corporation, directly or indirectly associated with the MISD, arising directly or indirectly out of participation in, or association with University Interscholastic League approved sports through the MISD.

  By my signature below, I hereby give authorization for the MISD, its athletic trainer(s), coach(es), associated physician(s) and student insurance personnel to share information concerning medical diagnosis and treatment of my student.

Parent/ Guardian Signature:_____ Date:_____

THIS FORM MUST BE ON FILE PRIOR TO ANY PRACTICE, SCRIMMAGE, OFFSEASON PROGRAM, SUMMER CONDTITIONING PROGRAM, OR CONTEST THAT IS HELD BEFORE, DURING, OR AFTER SCHOOL.

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INSURANCE

McKinney I.S.D. (MISD) does provide limited accident insurance coverage for all 7th through 12th grade students who participate in any activity sanctioned by the University Interscholastic League (UIL). **The insurance provided by the school is for activities that are sanctioned by UIL rules and regulations. Any competition in which the student participates that is NOT under UIL sanction will NOT be covered under school insurance.** However, parents must still assume responsibility for any injury sustained, regardless of any amounts paid by any insurance company. The policy provided by MISD is only intended to serve as an excess secondary insurance policy and **not to cover all expenses incurred**. Any injury occurring in, or as a result of, participation in a UIL sanctioned activity and/or MISD athletic activity, must be reported to the student's high school athletic trainer and/or coach the day of injury. Treatment must begin within 30 days from the injury and claims must be filed within 90 days of the injury. **It is the responsibility of the parent or guardian to file a claim.** An insurance claim form may be obtained from an Athletic Trainer or Middle School Coordinator.

STUDENT ATHLETE INJURYAND/OR ILLNESS REPORT

Any student athlete visiting a licensed medical Provider for any illness or injury must obtain a report signed by said Provider containing the following information.

- Nature of illness or injury
- Treatment of illness or injury including medication, protective gear, etc.
- Specific instructions regarding any restrictions from full participation in athletics, (e.g. may participate in non-contact environment, may not participate at all, etc.)
- Date of release that student athlete may participate in athletics with no restrictions; and
- The team physician together with a licensed athletic trainer shall have the final decision regarding whether the athlete will participate or play.

This signed report is to be submitted to the athletic trainer upon return to school, prior to any or all participation. **A copy of the clearance form must be obtained by the Sports Medicine Staff and presented to the appropriate coach prior to the activity.**

HEAD INJURY POLICY

McKinney ISD student athletes that receive three significant concussions during one calendar year may be restricted from participation for the remainder of that season. Concussions suffered by a student athlete will be evaluated on a case-by-case basis. MISD student athletes will be referred to a physician if they present with any concussion symptoms at any time. MISD will follow its concussion management guidelines in place. A copy of this information is available on the MISD athletic website and from MISD Athletic Trainers.

The ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) evaluation was created as a screening tool to assist sports medicine professionals in evaluating athletes after a suspected concussion. ImPACT was not designed to take the place of regular medical care and should not be used without proper oversight. ImPACT should never be used as a "stand alone" instrument to make decisions regarding whether an athlete returns to play and the ImPACT results should always be considered within the context of the overall medical care of the athlete.

By signing below, you give permission for your child to have a baseline ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered prior to participation at MISD. **There is no charge for the testing.** Further, by signing below, you authorize MISD to release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to your child's primary care physician, neurologist, treating physician, and/or other designated physician. Your signature also authorizes the disclosure of information about the treatment of a head injury, if one occurs, to your child's guidance counselor's, teachers, and coaches for the purposes of evaluating the need for temporary academic modifications and restricted athletic activity.

By signing below you acknowledge that you have read and understand the Insurance, Student Injury/Illness Report and Head Injury Policy. You do hereby agree that your son/daughter will abide by said rules.

Student Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

SAFETY WARNING: MUST BE SIGNED BY EACH FOOTBALL PARTICIPANT AND PARENT

No helmet can prevent all head and neck injuries a player might be exposed to while playing football. DO NOT use helmets to butt, ram or spear an opposing player. This conduct is a violation of football rules and such use can result in severe head or neck injuries, paralysis or death to you and possibly injury to your opponent.

I have read and understand the above Safety Warning.

Student Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

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PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

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

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 conditions which would make it hazardous to participate in an athletic event. *Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation.*

Question / Circle questions you don't know the answers to.	Yes	No	Explain any "Yes" Answers Here
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 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 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 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**			
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?			
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 sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)			
15. Have you ever had a sprain, or 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 below and explain. ☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Knee ☐ Chest ☐ Hand ☐ Shin/Calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Foot ☐ Back ☐ Wrist ☐ Upper Arm			
16. Do you want to weigh more or less than you do now?			
Do you lose weight regularly to meet weight requirements for you sport?			
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:

When was your first menstrual period?_____ When was your most recent 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, physician assistant, chiropractor, or nurse practitioner.

If, between the date of execution of this form 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.

I herby 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 student in question to penalties by the UIL.

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

THIS FORM MUST BE ON FILE PRIOR TO ANY PRACTICE, SCRIMMAGE, OFFSEASON PROGRAM, SUMMER CONDTITIONING PROGRAM, OR CONTEST THAT IS HELD BEFORE, DURING, OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____Date_____Signature_____

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PREPARTICIPATION PHYSICAL EVALUATION- PHYSICAL EXAMINATION

Student Name: _____ Date of Birth_____/_____/_____
Last First M.I.

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 any yes answers to specific questions on the student's Medical History Form. *** Local district policy requires a physical exam per school year not calendar year.**

Height_____ Weight_____ %Body fat (optional)_____ Pulse_____ BP___/___(___/____)

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			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

Examining Physician's Signature:_____
*****station-based examination only

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Foreman			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Examining Athletic Trainer's Signature:_____
*****station-based examination only

CLEARANCE Please Check or Circle One:

☐ Cleared

☐ Cleared after evaluations/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 Exam_____
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 games/matches.

PHYSICALS DATED BEFORE APRIL 1, 2014 WILL NOT BE ACCEPTED.