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

	YES	NO
41. Do you want to weigh more or less than you do now?	☐	☐
42. Do you lose weight regularly to meet weight requirements for you 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: _____

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION

STUDENT NAME (PRINT): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT: _____

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

Brachial blood pressure while sitting

VISION: R 20/_____ L 20/_____ CORRECTED: YES____ NO___ PUPILS: EQUAL ____ UNEQUAL:___

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation each year of high school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			

*Initials for station –based examination only

MUSULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other			

CLEARANCE

☐ Cleared for participation

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

☐ Not cleared for participation

Recommendations: _____

_____

Provider Name: _____ Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____