PHYSICIAN'S AND PARENTS' CERTIFICATE FOR ATHLETIC PARTICIPATION
UNIVERSITY INTERSCHOLASTIC LEAGUE AND ALDINE INDEPENDENT SCHOOL DISTRICT
Revised February 2015

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice, scrimmage, or contest before, during, or after school. A copy of the student's medical history and physical examination form signed by a physician must be on file at your school.

Student ID # _____ Gender: Male / Female Grade _____ School _____

Student's Name_____ Address _____

City/Zip _____ Home Phone _____ Birth Date _____ Age _____

Male Parent _____ Female Parent _____

Cell Phone _____ Cell Phone _____

Work Phone _____ Work Phone _____

ALTERNATE EMERGENCY CONTACT—Please list the emergency contact IN CASE a parent/guardian CANNOT be reached

Name _____ Relationship _____

Cell Phone _____ Work Phone _____

INSURANCE WAIVER

This section is to be filled out only if the parent chooses not to purchase the accident insurance offered through the school.

TO THE BOARD OF TRUSTEES OF THE ALDINE INDEPENDENT SCHOOL DISTRICT:

Gentlemen: The undersigned are the parents or legal guardians of _____ , a student in the Aldine Independent School District who intends to participate in the interscholastic athletic competition during the 20___-20___ school year. We have been advised that the Aldine Independent School District provides an insurance program for the protection of such students who participate in interscholastic athletic competition against bodily injury sustained by such students while training for or engaging in such competition.

The purpose of this is to inform you that the student named above is insured for any such bodily injuries he may sustain on insurance policies provided by the parents. The information regarding this coverage is provided below. IT IS MANDATORY THAT THIS INFORMATION BE PROVIDED. The student will not be issued any equipment or allowed to participate in any in-season or off-season practices or games until this information is on file at the school.

We accordingly instruct the Aldine Independent School District that **we do not desire the insurance coverage offered through the district** for such student and we do hereby expressly waive any future claim or cause of action that we or the student may have against the Aldine Independent School District as a result of any bodily injuries sustained in interscholastic athletic competition, whether while training for or engaging in such competition, during the 20___-20___ school year.

THE FOLLOWING MUST BE SIGNED IN FRONT OF A NOTARY PUBLIC

X_____ **X**_____ _____

Signature of Student Athlete **Signature of Parent/Legal Guardian** **Date**

INSURANCE INFORMATION:

Student's Health Insurance Provider _____

Policy Number _____ Group Number _____

Phone Number _____ Name of Insured _____

IF ANY OF THE ABOVE INFORMATION CHANGES, CONTACT THE ATHLETIC TRAINER OR CAMPUS ATHLETIC COORDINATOR AT THE SCHOOL IMMEDIATELY WITH THOSE CHANGES!

Subscribed and sworn to before me this _____ day of _____, 20_____

_____

Notary Public in and for Harris County, Texas *Notary Seal or Stamp*

PREPARTICIPATION PHYSICAL EVALUATION (PART 1)—MEDICAL HISTORY (TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN)

Explain "Yes" answers on an additional sheet. Circle questions you don't know the answers to. 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.

1. Have you had a medical illness or injury since your last check up or sports physical? Y N

2. Have you been hospitalized overnight in the past year? Y N
Have you ever had surgery? Y N

3. Have you ever had prior testing for the heart ordered by a physician? Y N
Have you ever passed out during or after exercise? Y N
Have you ever had chest pain during or after exercise? Y N
Do you get tired more quickly than your friends do during exercise? Y N
Have you ever had racing of your heart or skipped heartbeats? Y N
Have you had high blood pressure or high cholesterol? Y N
Have you ever been told you have a heart murmur? Y N
Has any family member or relative died of heart problems or of sudden unexpected Death before the age 50? Y N
Has any member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? Y N
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? Y N
Has a physician ever denied or restricted your participation in sports for any heart problems? Y N

4. Have you ever had a head injury or concussion? Y N
Have you ever been knocked out, become unconscious, or lost your memory? Y N
If Yes, how many times_____
When was the last concussion?_____
How severe was each one? (Explain below)
Have you ever had a seizure? Y N
Do you have frequent or severe headaches? Y N
Have you ever had numbness or tingling in your arms, hands, legs, or feet? Y N
Have you ever had a stinger, burner, or pinched nerve? Y N

5. Are you missing any paired organs? Y N

6. Are you under a doctor's care? Y N

7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler? Y N

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? Y N

10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Y N

11. Have you ever become ill from exercising in the heat? Y N

12. Have you had any problems with your eyes or vision? Y N

13. Have you ever gotten unexpectedly short of breath with exercise? Y N
Do you have asthma?
Do you have seasonal allergies that require medical treatment? Y N

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)? Y N

15. Have you ever had a sprain, strain, or swelling after an injury? Y N
Have you ever broken or fractured any bones or dislocated any joints? Y N
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Y N
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? Y N
Do you lose weight regularly to meet weight requirements for sport? Y N

17. Do you feel stressed out? Y N

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 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?_____

For school use only: This Medical History Form was reviewed by:
Name_____ Date_____ Sign_____

- It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the Aldine Independent School District 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 district 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 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 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 X_____ Date_____
Parent X_____ Date_____

PREPARTICIPATION PHYSICAL EVALUATION (PART 2)—
(To be completed by examining physician or physician's designee prior to beginning physical examination)

Student's Name_____

Sex_____ Age _____ Date of Birth _____

Height_____ Weight _____

% Body Fat (optional) _____ Pulse _____

BP _____/_____ (_____/_____)

Vision R 20/_____ L 20/_____ Corrected? Y N

Pupils: Equal_____ Unequal_____

PREPARTICIPATION PHYSICAL EVALUATION (PART 3)—

PHYSICAL EXAMINATION (TO BE COMPLETED AND SIGNED BY A PHYSICIAN, A PHYSICIAN ASSISTANT LICENSED BY A STATE BOARD OF PHYSICAN 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.

***station-based examination only**

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

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

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.

Examiner's Name (Print)_____

Date of Examination _____

Address_____

Phone _____

Signature_____