

TISD Student ID # _____ Student's Last Name _____ / Student's First Name _____ / Student's Middle Initial _____ 2020-21 GRADE _____

Gender _____ Date of Birth _____ SCHOOL attending in 2020-21: TOMBALL JH CREEKSIDE PARK JH WILLOW WOOD JH
 TOMBALL HS TOMBALL MEMORIAL HS

Circle the sport(s) in which you plan to participate:

Band Baseball Basketball Cheerleading Cross Country Drill Team Football Golf Manager ROTC Soccer
 Softball Student Trainer Swimming & Diving Tennis Track & Field Volleyball OTHER: _____

PARENT/GUARDIAN 1: _____ Home Phone: _____ Cell Phone: _____ E-Mail Address: _____	PARENT/GUARDIAN 2: _____ Home Phone: _____ Cell Phone: _____ E-Mail Address: _____
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Allergies to medication or other (please list): _____

Any medications taken regularly (please list): _____

Any medical concerns/conditions: _____

Sickle Cell/Trait: YES / NO Diabetes: YES / NO Epilepsy/ Seizure Disorder: YES / NO Concussions: NO / YES- Dates: _____

CONSENT TO TREAT

It is understood that even though the athlete, whenever needed wears protective equipment, the possibility of an accident still remains. Neither the UIL nor Tomball ISD 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 because 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 might limit this student's participation, I agree to notify the school authorities of such illness or injury.

RELEASE TO RETURN TO PARTICIPATION AFTER ANY MEDICAL CONSULTATION

I understand that any student who seek medical attention from a HealthCare Provider for any injury or illness, regardless of whether they are removed from or have restrictions placed on their ability to participate, CANNOT return to athletic participation until a signed and dated physician's release has been provided to the Licensed Athletic Trainer (LAT) or designee. Parental authorization or notification will NOT be accepted in place of the medical release/note. This includes any injuries/ illness that may not be school related (Club/ off campus). The MD notes should include a diagnosis with any restriction or treatments; these are not "attendance" notes.

REQUIRED ONLINE FORMS & MEDICATION PERMISSION

Athletic paperwork and pre-participation forms for Tomball ISD is online. It is mandatory that all 7th-12th grade prospective student-athletes fill out UIL and TISD paperwork before they will be allowed to participate in any practice or contest before, during or after school, including tryouts. The website is designed to stream line the process, and conserve valuable resources. Go to TOMBALLISD.RANKONESPORT.COM and complete the Athletic Participation form which includes all mandatory UIL paperwork. Please have your students ID number available when filling out the paperwork. A confirmation email will be received when all paperwork is completed online.

****The Physical & Medical History must still be turned into an Athletic Trainer at the athlete's high school or respective coach at middle school.****
 ****This piece of paper must be signed and stamped by the physician. The physical must also be signed by parent, and student-athlete.****

Licensed Athletic Trainers (LAT) of Tomball ISD are hereby given my acknowledgment and consent to administer non-prescription over-the-counter medication to my child. A complete list of over-the-counter medications is available from each campus upon request. I also give consent to administer prescription medication when prescribed by my child's physician and accompanied by a Medication Permission Form. The original prescription label must be on the container.

MEDICAL INFORMATION

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians, school personnel and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

X Parent/Guardian Sign (required): _____ Date: _____

STUDENT – PARENT/GUARDIAN SECTION

This **MEDICAL HISTORY FORM** must be completed annually by parent/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 condition, which would make it hazardous to participate in an athletic event. **Explain all "Yes" answers. 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.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur ?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden unexpected death before age 50? WHO:	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member been diagnosed with enlarged heart (dilated cardiomyopathy), Hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? WHO:	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a head injury or concussion ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory ?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times ? _____ When was the last concussion ? _____		
How severe was each one? (Explain)		
Have you ever had a seizure ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, or pinched nerve ?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you missing any paired organs ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you under a doctor's care ?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler ?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision ?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had a sprain, strain, or swelling after injury ?	<input type="checkbox"/>	<input type="checkbox"/>
Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot <input type="checkbox"/> Chest		
16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever been diagnosed with/or treated for sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
19. Females Only: 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? _____		
20. Males Only: Do you have two Testicles?	<input type="checkbox"/>	<input type="checkbox"/>
21. Males Only: Do you have any Testicular swelling or masses?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL EXAMINER SECTION

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 "yes" answers to specific questions on the student's **MEDICAL HISTORY FORM** in the left column.

Height: _____ Weight: _____ Pulse: _____

BP: _____ / _____ (_____ / _____ : _____ / _____)
Brachial Blood Pressure while sitting

Vision: R - 20/ _____ L - 20/ _____ Corrected: Y N

Pupils: Equal / Unequal %Body Fat (optional): _____
Normal Abnormal Initials*

MEDICAL	Normal	Abnormal	Initials*
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart – Auscultation Standing			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hyper-mobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE _____ * Station-based examination only

O CLEARED
O CLEARED AFTER COMPLETING EVALUATION/REHABILITATION FOR: _____

O NOT CLEARED
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.

Date of Examination: _____

Stamp or Label:
MD Name: _____
Address: _____
Phone Number: _____

Physician's Signature: _____
EXPLAIN 'YES' ANSWERS (attach another sheet if necessary): _____

An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

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 TISD and the UIL.

X Parent/Guardian Sign (required): _____ Student Sign (required): _____ Date: _____