



**Dickinson Independent School District
University Interscholastic League (UIL) Pre-Participation Form
This Physical is valid for the 2018-2019 School Year**

2018-2019

Attention: This form must be signed by BOTH the student and the parent/guardian and be on file in the athletic trainer's office PRIOR TO PARTICIPATION in any tryout, practice, scrimmage, or contest before, during or after school.

This form must be completed in Blue or Black Ink. Please return this form to the Athletic Training room in the Field House.

Please check which activities this physical is for:

Fine Arts/Band Athletics

Grade for the 2018-2019 school year: 7 8 9 10 11 12 **School Attending:** **DHS** **MJHS** **KJHS**

Name Last: _____ First: _____ MI: _____ Sex (Circle): Male Female

Student ID (Lunch #): _____ **Birth Date:** _____ **Age:** _____ **Student Cell:** _____

Ethnicity (please circle): African American American Indian Asian Hispanic Caucasian Other

Home Address: _____ **Primary Phone #:** _____

City/State _____ Zip Code _____

Guardian 1 Name: _____ **Mobile #:** _____ sólo en Español

Guardian 2 Name: _____ **Mobile #:** _____ sólo en Español

Emergency Information—If Parent/Guardian can not be reached, in case of an emergency, please contact:

Name _____ **Phone #** _____ **Relation** _____ sólo en Español

Allergies to medicine or other _____

Current medicines taken _____

Any medical conditions _____

<p>Medical History <i>Does your child have a previous history of:</i></p> <table border="0"> <tr> <td></td> <td align="center">Yes</td> <td align="center">No</td> </tr> <tr> <td>Heart Trouble or Disease?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Being knocked out/Unconscious?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Epilepsy?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Seizures/Convulsions?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Sickle Cell Trait/Disease?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Asthma?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td> Does your asthma require an inhaler? ..</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes?</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Contacts/Glasses?.....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>		Yes	No	Heart Trouble or Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	Being knocked out/Unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy?.....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	Does your asthma require an inhaler? ..	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Contacts/Glasses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<p align="center">Insurance Information</p> <p>Insurance Company: _____</p> <p>Policy Holder: _____</p> <p>Policy Number: _____</p> <p>Group Number: _____</p> <p>Type: HMO PPO POS Other</p>	<p><input type="checkbox"/> I DO NOT have insurance coverage at this time (please check this box if applicable)</p> <p>Dickinson ISD provides secondary accidental injury insurance coverage for students who participate in UIL sanctioned activities for grades 7-12. The parent/guardian's insurance policy is always the primary carrier with the DISD insurance coverage as a secondary carrier. This policy pays per a schedule of benefits and covers injury, not illness. This insurance policy is available to all student athletes and is offered to assist in the diagnoses and/or treatment of any injuries that may occur from participating in athletics. It is not a replacement for any other insurance policy, and is not all-inclusive. This policy is provided for UIL participants at no cost to the parent/guardian. It is the responsibility of the parent/guardian to file any and all insurance claims within 90 days of the injury with the forms provided by the DISD Athletic Trainers.</p>
		Yes	No																													
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For information about or to enroll your student in accident insurance, please visit the following website:
<https://www.texaskidsfirst.com/Plans.aspx>

Football Helmet Warning: No Helmet can prevent all neck, head or back injuries a player may receive while participating in football. Do not use the helmet to butt, ram or spear an opposing player. This is in violation of the football rules and such use can result in severe head or neck injuries, paralysis or death to you and possible injury to your opponent.

I give the DISD Athletic Trainers permission to administer the baseline concussion/ImPACT test at anytime during the school year.

By my signature, I further authorize and consent to a Licensed Athletic Trainer to administer non-prescription medication to said student under standing orders with the team designated physician, or representative. Further consent is also hereby given to a Licensed Athletic Trainer to administer prescription and non-prescription medication (when appropriate) to said student when prescribed by the team physician or representative, and/or student's personal physician or representative. I consent for medically appropriate treatment (modalities, therapeutic exercise, techniques etc.) to be performed on my child when deemed appropriate by the staff athletic trainers.

Your signature below gives authorization that is necessary for the Dickinson Independent School District, and/or staff members, its licensed athletic trainers, coaches, associated physicians, school personnel and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Please turn this packet into the Athletic Training Room

Signature of parent/guardian: _____ **Date:** _____

Signature of student athlete: _____ **Date:** _____

ACKNOWLEDGEMENT OF RULES

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 session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name _____ Date of Birth _____

Current School _____

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

Furthermore, as a condition of participation and for the purpose of ensuring compliance with University Interscholastic League (UIL) rules, I consent to the disclosure of personally identifiable information, including information that may be subject to the Family Educational Rights and Privacy Act (FERPA), regarding the above named student between and among the following: the high school or middle school where the student currently attends or has attended; any school the student transfers to; the relevant District Executive Committee and the UIL. I further understand that all information relevant to the student's UIL eligibility and compliance with other UIL rules may be discussed and considered in a public forum. I acknowledge that revocation of this consent must be in writing and delivered to the student's school and the UIL.

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 high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs 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 to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues including concussions and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

The UIL Parent Information Manual is located at www.uiltexas.org/files/athletics/manuals/parent-information-manual.pdf.

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

To the Parent: Check any activity in which this student is allowed to participate.

Baseball	Football	Softball	Tennis
Basketball	Golf	Swimming & Diving	Track & Field
Cross Country	Soccer	Team Tennis	Volleyball
Wrestling			

Date _____

Signature of parent or guardian _____

Street address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: See Section 1209 of the Constitution and Contest Rules).
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, football, soccer, softball, or volleyball
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

GENERAL ELIGIBILITY RULES

According to UIL standards, students could be eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See Section 446 of the Constitution and Contest Rules for exception).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time students in the participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the Constitution and Contest Rules).
- have observed all provisions of the Awards Rule.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.

I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

I have read the regulations cited above and agree to follow the rules.

Date

Signature of student



CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student _____

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.

- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Headache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete/cheerleader shall be removed from practice or participation immediately if suspected to have sustained a concussion. Every student-athlete/cheerleader suspected of sustaining a concussion shall be seen by a physician before they may return to athletic or cheerleading participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete/cheerleader may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:

A student removed from an interscholastic athletics practice or competition (including per UIL rule, cheerleading) under Section 38.156 may not be permitted to practice or participate again following the force or impact believed to have caused the concussion until:

(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student's parent or guardian or another person with legal authority to make medical decisions for the student;

(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;

(3) the treating physician has provided a written statement indicating that, in the physician's professional judgment, it is safe for the student to return to play; and

(4) the student and the student's parent or guardian or another person with legal authority to make medical decisions for the student:

(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;

(B) have provided the treating physician's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and

(C) have signed a consent form indicating that the person signing:

(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;

(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;

(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and

(iv) understands the immunity provisions under Section 38.159.

Parent or Guardian Signature

Date

Student Signature

Date



University Interscholastic League



Parent and Student Agreement/Acknowledgement Form Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- 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.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uiltexas.org. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uiltexas.org. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

School Year (to be completed annually) _____

Dickinson Independent School District

Athletic/Fine Arts Code of Conduct

All Dickinson Independent School District athletes are subject to guidelines set forth in the Student Handbook as approved by our School Board and Administrators. Any athlete violating school district policy will be disciplined like all other students. In addition, he/she may be dismissed from the team or other privileges may be taken away at the discretion of the coach and/or administration.

Other Rules of Conduct

A student is not required to take part in athletics nor is it required for graduation. Participation in athletics is a privilege. Consequently, when high ideals and standards are violated, this privilege can be revoked. Dickinson Independent School District athletes will act with pride and dignity.

On the Field or Court – The athlete must never use profanity or resort to illegal tactics. They must learn that both winning and losing are part of the game and that they have to exhibit good sportsmanship and win graciously. Fighting, temper fits, flagrant violations of rules, etc., will not be tolerated. Total respect for officials is an absolute must. Discussion of calls made by officials will be done by the coach. Any behavior contrary to the above mentioned or any other act which is not conducive to good sportsmanship may result in removal from the contest and possible expulsion from the team.

Quitting the Team – An athlete who quits a sport after the first contest will not be allowed to start another sport until the season ends for the sport the athlete quits, or unless both coaches feel it is in the best interest of the team and the student. Additionally, they will not be recommended for post-season awards and/or accolades or be eligible for their letter jacket.

In the Classroom – It is expected that the athlete be on time and conduct themselves in a manner that will reflect positively on the team. Call your coach if you are absent from school. All school rules and policies will be followed.

Equipment and Facilities – Proper care of equipment and facilities is a must. Equipment checked out to athletes will be returned at the end of the season or an explanation will be discussed with the coach. If an athlete deliberately abuses equipment or facilities actions will be taken accordingly. If equipment is not returned, the student will be placed on the fine list. Malicious destruction of any school or individual's equipment or property, home or away, will not be tolerated. Additionally, students must be supervised by their coach when using any Dickinson ISD facility.

Theft - Theft of any kind will not be tolerated, and will be dealt with accordingly.

Bullying and Hazing – Hazing, or any type of physical or mental bullying, will not be tolerated in any way. If you or someone you know are a victim of hazing or bullying, you should report the offense to your coach immediately.

Alcoholic Beverages and Drug Use - The use or possession of alcoholic beverages, tobacco, steroids, drugs, narcotics, or hallucinating agents by any athletic program participant is prohibited. DISD local policy will be observed.

Each head coach of a sport will make decisions concerning the discipline of an athlete. If it is a severe penalty, they may consult with the athletic director or school administration.

University Interscholastic League Rules will be observed by our athletic department.

Parent Code of Conduct

Remember that you are at the contest to support your team, and to enjoy the skill and competition, not to intimidate or ridicule the teams, its fans or officials. The ticket is a privilege to observe the contest. Parents and spectators need to be aware that the school will remove them from the premises and will prohibit them from attending future contests due to undesirable behavior. There is no such thing as a "right" to attend interscholastic athletics.

For a copy of the manual that is specific to your sport, or the parent manual for athletics, please visit the following website:

<http://www.uiltexas.org/athletics/manuals>

Signature of parent/guardian: _____ Date: _____

Signature of student athlete: _____ Date: _____



SUDDEN CARDIAC ARREST (SCA) AWARENESS FORM

The Basic Facts on Sudden Cardiac Arrest

Website Resources:

American Heart Association:
www.heart.org

Lead Author: Arnold Fenrich, MD
and Benjamin Levine, MD

Additional Reviewers: UIL Medical
Advisory Committee

Revised 2016

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What causes Sudden Cardiac Arrest?

Inherited (passed on from family) **conditions present at birth of the heart muscle:**

Hypertrophic Cardiomyopathy – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.

Arrhythmogenic Right Ventricular Cardiomyopathy – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.

Marfan Syndrome – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.

Inherited conditions present at birth of the electrical system:

Long QT Syndrome – abnormality in the ion channels (electrical system) of the heart.

Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome – other types of electrical abnormalities that are rare but run in families.

NonInherited (not passed on from the family, but still present at birth) **conditions:**

Coronary Artery Abnormalities – abnormality of the blood vessels that supply blood to the heart muscle. This is the second most common cause of sudden cardiac arrest in athletes in the U.S.

Aortic valve abnormalities – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.

Non-compaction Cardiomyopathy – a condition where the heart muscle does not develop normally.

Wolff-Parkinson-White Syndrome – an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.

Conditions not present at birth but acquired later in life:

Commotio Cordis – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.

Myocarditis – infection or inflammation of the heart, usually caused by a virus.

Recreational/Performance-Enhancing drug use.

Idiopathic: Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms and warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.

What is the treatment for Sudden Cardiac Arrest?

Time is critical and an immediate response is vital.

- **CALL 911**
- **Begin CPR**
- **Use an Automated External Defibrillator (AED)**

What are ways to screen for Sudden Cardiac Arrest?

The American Heart Association recommends a pre-participation history and physical including 14 important cardiac elements.

The UIL *Pre-Participation Physical Evaluation – Medical History* form includes ALL 14 of these important cardiac elements and is mandatory annually.

What are the current recommendations for screening young athletes?

The University Interscholastic League requires use of the specific Preparticipation Medical History form on a yearly basis. This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

It is important to know if any family member died suddenly during physical activity or during a seizure. It is also important to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually because it is essential to identify those at risk for sudden cardiac death.

The University Interscholastic League requires the Preparticipation Physical Examination form prior to junior high athletic participation and again prior to the 1st and 3rd years of high school participation. The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no additional evaluation or testing is recommended for cardiac issues/concerns.

Are there additional options available to screen for cardiac conditions?

Additional screening using an electrocardiogram (ECG) and/or an echocardiogram (Echo) is readily available to all athletes from their personal physicians, but is not mandatory, and is generally not recommended by either the American Heart Association (AHA) or the American College of Cardiology (ACC). Limitations of additional screening include the possibility (~10%) of “false positives”, which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation. There is also a possibility of “false negatives”, since not all cardiac conditions will be identified by additional screening.

When should a student athlete see a heart specialist?

If a qualified examiner has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist may perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, may also be done. The specialist may also order a treadmill exercise test and/or a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can Sudden Cardiac Arrest be prevented just through proper screening?

A proper evaluation (Preparticipation Physical Evaluation – Medical History) should find many, but not all, conditions that could cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus. This is why a medical history and a review of the family health history need to be performed on a yearly basis. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

Texas Senate Bill 7 requires that at any school sponsored athletic event or team practice in Texas public high schools the following must be available:

- An AED is in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium
- All coaches, athletic trainers, PE teacher, nurses, band directors and cheerleader sponsors are certified in cardiopulmonary resuscitation (CPR) and the use of the AED.

- Each school has a developed safety procedure to respond to a medical emergency involving a cardiac arrest.

The American Academy of Pediatrics recommends the AED should be placed in a central location that is accessible and ideally no more than a 1 to 1 1/2 minute walk from any location and that a call is made to activate 911 emergency system while the AED is being retrieved.

Student & Parent/Guardian Signatures

I certify that I have read and understand the above information.

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Student Signature

Student Name (Print)

Date

INFORMED CONSENT FOR TREATMENT AND PREVENTATIVE HEALTH CARE SERVICES

Please Read Carefully and Complete the Consent Form to Allow Your Child to Be Treated at the Gator HOPE Clinic

Patient Name _____ Date of Birth _____
Last First MI (MM/DD/YY)
Address _____ City _____ Zip _____
Parent/Guardian Name _____
Last First MI
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____

I authorize the physician assistant to provide the necessary and/or advisable treatment for my child. I give my permission for medical evaluation, treatment and/or procedures for my child's medical condition within the capabilities of the facility and its personnel. I agree to completely disclose all known allergies, chronic illnesses, prior or current medications as well as any previous adverse drug reactions

Signed _____ Date _____

Allergies to medications _____ Current Medications _____

Past Medical History _____ School _____

Sex: Male or Female Pharmacy Name and Location _____

All services within the clinic are provided at no cost to the student with the exception of Sports Physicals. However we can better serve your overall needs if we know whether your child has health insurance

___Medicaid ___CHIP ___Private Health Ins ___None

The following information may be released for the benefit of my child:
___Clinically pertinent information ___History and Physical ___Immunizations ___Other(specify) _____
Information may be disclosed to:
___Principal ___School Counselor ___School Nurse ___Primary Physician ___Other(specify) _____

Right to revoke authorization

Except to the extent that action already taken pursuant to this authorization, this consent will be in effect until revoked at any time by submitting a notice in writing to the Physician Assistant.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility, its employees, officers and physician assistant are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or guardian who may request disclosure

I understand that I am not required to sign this authorization and my request for services above will not be denied if I do not sign this form below unless specified above under *other* information may be disclosed. I can inspect or copy the protected health information to be used or discussed. I authorize Gator HOPE Clinic to release the protected health information specified above:

Name _____ Date _____

CONSENTIMIENTO INFORMADO PARA RECIBIR TRATAMIENTO Y OTROS SERVICIOS DE ATENCION PREVENTIVA

Lea cuidadosamente y complete el siguiente formulario de consentimiento para que su niño/a pueda recibir tratamiento en la clinica

Nombre del paciente _____ Fecha de nacimiento _____
Apellido Primer Nombre Medio Nombre MM/DD/YY

Direccion _____ Ciudad _____Codigo Postal _____

Nombre del Padre/Tutor _____
Apellido Primer Nombre Medio Nombre

Telefono de la casa _____ Celular _____

Telefono del trabajo _____ Email _____

Autorizo a que a certificado medico brinde el tratamiento necesario y/o recomendado a mi hijo/a. Autorizo para que se realicen procedimientos y se brinde tratamiento al evaluar y tratar la condicion medica de mi hijo/a dentro de las capacidades de la clinica y su personal. Accedo a informar sobre todas las alergias conocidas, enfermedades cronicas, medicamentos o drogas anteriores que hayan producido reacciones adversas y todos los medicamentos usados actualmente.

Firma: _____ Fecha _____

Alergias: _____ Medicamentos Actuales: _____

Antecedentes Medicos: _____ Escuela: _____

Sexo: Male o Female Nombre de farmacia y direccion: _____

Todos los servicios de la clinica son proporcionados sin al el estudiante, con la exception de los deportes fisicos. Sin embargo, podemos server mayor a sus necesidades globales si podemos si hijo tiene seguro de salud.

___ Medicaid ___ CHIP ___ Seguro Medico ___ Nada

La siguiente informacion puede entregarse al personal escolar por el bien de mi hijo/a
___ Informacion clinicamente necesario ___ Antecedentes y examines fisicas ___ Vacunas ___ Otra (especificar) _____
La informacion puede entregarse a:
___ Directora ___ Consejera Escolar ___ Enfermera Escolar ___ Medico Principal ___ Otra (especificar) _____

Derechos a revocar la autorizacion

Pero hasta el punto que accion ya tomado segun esta autorizacion este consentimiento sera vigente caja revoco en tiempo sometiendo una nota por escrito al Physician Assistant.

La informacion puede entregarse a otras personas

Entiendo que la persona que recibio informacion bajo esta autorizacion puede a su vez entregar esa informacion a otras personas y entonces la informacion ya no estara protegida por la Ley de Transportabilidad y Roesponsabilidad de los seguros medicos de 1996. La clinica, sus empleados, funcionarios y medicos quedan liberados de toda responsabilidad legal por entregar la informacion mencionada en la medida indicada y autorizada en la presente

Firma del paciente o representante personal que puede solicitar que se entregue informacion

Entiendo que no tengo que firmar esta autorizacion, y que si no firmo no se me negara tratamiento ni el pago de servicios, a menos que esto se indique en la seccion *Otra* arriba. Puedo examiner o copier la informacion medica protegida que se va a usar o entregar. Autorizo Gator HOPE Clinic a entregar la informacion medica protegida especificada en este document:

Firma: _____ Fecha: _____

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 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's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

	Yes	No		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"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<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"/>	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"/>
Have you ever passed out during or after exercise?	<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 ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<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 had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____					
How severe was each one? (Explain below)			<i>Females Only</i>		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
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"/>	<i>Males Only</i>		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have two testicles? _____		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you have any testicular swelling or masses? _____		
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"/>			

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.

****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):**

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

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. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal

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 on the reverse side. * **Local district policy may require an annual physical exam.**

	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)			

MUSCULOSKELETAL			
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: _____

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 Examination: _____

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.