

School Year: 2009-2010

Grade: _____

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| CLEAR CREEK INDEPENDENT SCHOOL DISTRICT UNIVERSITY INTERSCHOLASTIC LEAGUE PHYSICIAN'S & PARENT CERTIFICATE FOR PARTICIPATION |
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Attention: This form **MUST** be filled out **COMPLETELY**, signed by either a Physician, a Physician Assistant, licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic, signed by both the student and parent/guardian, and on file with the athletic trainer **BEFORE** the student will be allowed to participate in any class period practice, tryout, practice session, scrimmage, or game.

Name: _____ D.O.B. _____ Sex: M / F

Parent/Guardian Name: _____ Home Phone # () _____

Address: _____
(Street Address, City, State, Zip Code)

Parent's E-mail Address: _____

Mom: Home # () _____ Work # () _____ Other # () _____

Dad: Home # () _____ Work # () _____ Other # () _____

In case of emergency and parent / guardian cannot be reached, please contact:

Name: _____ Phone: _____

School: _____

Sport / Activity: _____

School Year: 2009-2010

Grade: _____

| |
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| CLEAR CREEK INDEPENDENT SCHOOL DISTRICT EMERGENCY CARD / CONSENT FOR TREATMENT |
|--|

Name: _____ D.O.B. _____ Sex: M / F

Parent/Guardian Name: _____ Home Phone # () _____

Address: _____
(Street Address, City, State, Zip Code)

Mom: Home # () _____ Work # () _____ Other # () _____

Dad: Home # () _____ Work # () _____ Other # () _____

In case of emergency and parent / guardian cannot be reached, please contact:

Name: _____ Phone # () _____

In the event that the parents / guardian of the above named student cannot be contacted, I hereby accept the emergency services of the team physician and athletic trainer and hereby authorize the athletic trainer, coach, and other school officials to sign such papers as may be required to obtain immediate medical attention necessary for the welfare and safety of such student. 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 the said student.

_____ Date

_____ Student Signature

_____ Parent / Guardian Signature

REQUIRED INSURANCE INFORMATION

The undersigned are the parents / guardians of _____, a student in the Clear Creek Independent School District who intends to participate in interscholastic competition during the 2009–2010 school year. We have been advised that the Clear Creek Independent School District provides the opportunity to purchase an insurance program for protection of such students who participate in interscholastic competition against bodily injury sustained by such students while training for or engaging in such competition. Based on the above acknowledgement, we declare the following (THIS IS REQUIRED, please check all that apply):

- ___ A. We have **NO** personal insurance provider coverage and **DO NOT** desire to purchase the insurance coverage offered through the school district.
- ___ B. We **DO** choose to purchase the insurance coverage offered through the school district.
Plan purchased: _____
- ___ C. We choose to have our child covered by a personal insurance provider **ONLY**.
Please provide the following information:
Insurance Company: _____ Phone # () _____
Name of Insured: _____ Group Policy # _____

We further acknowledge that, pursuant to the Texas Tort Claims Act, the Clear Creek Independent School District cannot be held liable for any injuries sustained in training or interscholastic competition, and we therefore agree that no legal action may be brought against the District arising from any such injuries.

WARNING: No helmet can prevent all head or neck injuries a player might receive while participating in football. Do not use the helmet to butt, ram, or spear an opposing player. This is a 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.

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

Must be signed by all

| | | |
|------|-------------------|-----------------------------|
| Date | Student Signature | Parent / Guardian Signature |
|------|-------------------|-----------------------------|

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REQUIRED INSURANCE INFORMATION (please check & fill out ALL that apply):

- ___ A. **NO** insurance provider coverage at all.
- ___ B. CCISD School Insurance provider coverage: Plan purchased: _____
- ___ C. Personal insurance provider coverage:
Insurance Company: _____ Phone # () _____
Name of Insured: _____ Group Policy # _____

MEDICAL HISTORY (respond to ALL)

| | | |
|---------------------------------|--|--------------------|
| Allergies? Yes / No | Allergies to medications? Yes / No | Asthma? Yes / No |
| Heart Trouble? Yes / No | Contacts/Glasses? Yes / No | Epilepsy? Yes / No |
| History of Concussion? Yes / No | Sickle Cell Trait or Disease? Yes / No | Diabetes? Yes / No |

Please explain all "Yes" answers and list all drug allergies and/or medications taken regularly: _____

I hereby certify that all of the above information is true to the best of my knowledge.

| | | |
|------|-------------------|-----------------------------|
| Date | Student Signature | Parent / Guardian Signature |
|------|-------------------|-----------------------------|

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

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. 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 | | 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 passed out during or after exercise? | <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 had chest pain 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"/> |
| Do you get tired more quickly than your friends do during exercise? | <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 ever had racing of your heart or skipped heartbeats? | <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 had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| 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"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| 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"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| 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"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| 4. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <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"/> |
| If yes, how many _____ When was the last _____ | | | Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| times? _____ concussion? | | | 17. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain below) | | | 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | Females Only | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. When was your first menstrual period? _____ | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| 5. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 6. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____ | | |
| 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"/> | 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. | | |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | **EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): | | |
| 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"/> | | | |

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: _____

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*

| | 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.