PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

2020

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an 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
1. Have you had a medical illness or injury since your last check up or physical?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
Have you ever had surgery?	☐	☐
3. Have you ever had prior testing for the heart ordered by a physician?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
If yes, how many times? _____		
When was your last concussion? _____		
How severe was each one? (Explain below)		
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5. Are you missing any paired organs?	☐	☐
6. Are you under a doctor's care?	☐	☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
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?	☐	☐
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐

	Yes	No
13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

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?	☐	☐
17. Do you feel stressed out?	☐	☐
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 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? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

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

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

It is understood that even though protective equipment is worn by athletes, 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 participation, 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, PERFORMANCE 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 participation and again prior to first and third years of high school 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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

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 performance/ games/matches.

Name:_____

Date of Birth:_____

School:_____

Grade:_____

ASTHMA MEDICINE PLAN

Steps to a HealthierSan Antonio

You can use the colors of a traffic light to help learn about your asthma medicines.

1. ***GREEN*** means ***GO***. Use your everyday preventive medicines.
2. ***YELLOW*** means ***CAUTION***. Use quick-relief medicine.
3. ***RED*** means ***DANGER***! Use extra medicines and call your doctor **NOW**!

GREEN means *GO!!!!*

*** Breathing is good.**
*** No cough or wheeze.**
*** Can work and play.**

USE EVERYDAY PREVENTIVE MEDICINES.

Medicine	How much to take	Times	Circle One
			Home/School
			Home/School
			Home/School

****20 minutes before sports, use this medicine:**

_____

YELLOW means *CAUTION!!!!*

Cough

Wheeze

Tight Chest

Wake up at Night

1. KEEP TAKING GREEN ZONE MEDICINES.
2. START TAKING QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD.

Medicine	How much to take	Times to take
Albuterol/Xopenex		now and every 4 to 6 hours

****If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN**

****IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR**

RED means *DANGER!!!*

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GET HELP FROM A DOCTOR NOW !!!

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How much to take
Albuterol/Xopenex	

You may repeat this dose _____ times, 20 minutes apart.

☎☎ **CALL 911 (EMS) IF:** Lips or fingernails are blue, or ☎☎
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Physician recommendations for Air Quality Health Alert Days: (Check one)

□ Exercise as tolerated □ No vigorous outdoor activity □ Other _____

Physician recommendations for medication self-administration: (Check one)

□ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events

□ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events.

Printed Name of Health Care Provider _____ Signature of Health Care Provider _____ Phone Number _____ Date _____

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child to be photographed for identification purposes and for my child's physician to share written or verbal information with the school nurse for the duration of this school year.

Signature of parent/guardian _____ Date _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio

White Copy: Patient Yellow Copy: Patient or School Pink Copy: Physician

Nombre:_____

Fecha de nacimiento:_____

Escuela_____

Grado_____

PLAN PARA LAS MEDICINAS DEL ASMA

Usted puede usar los colores del semáforo para ayudarse a aprender sobre sus medicinas.

1. ***VERDE*** significa ***SIGA***. Use sus medicinas preventivas de todos los dias.
2. ***AMARILLO*** significa ***PRECAUCIÓN***. Use medicinas para rápido alivio.
3. ***ROJO*** significa ***¡Peligro!*** Use medicinas adicionales y llame a su doctor ***¡YA!***

VERDE significa *¡SIGA!!!*

*** La respiración está bien.**
*** Sin tos o pillido/silbido.**
*** Puede trabajar o jugar.**

USE LAS MEDICINAS PREVENTIVAS DE TODOS LOS DÍAS

Medicina	Dosis	Horario	Encierre Uno en un Círculo
			Casa / Escuela
			Casa / Escuela
			Casa / Escuela

**** 20 minutos antes de hacer deporte, use esta medicina:**

_____

AMARILLO significa *¡PRECAUCIÓN!!!*

Toser

Silbido

Pecho Apretado

Despertar en la Noche

1. SIGA TOMANDO LAS MEDICINAS DE LA ZONA VERDE.
2. COMIENCE A TOMAR LAS MEDICINAS PARA RÁPIDO ALIVIO, EVITANDO QUE EL ATAQUE DE ASMA EMPEORE.

Medicina	Dosis	Veces que hay que tomarla
Albuterol/Xopenex		ahora y cada 4 ó 6 horas

****** Si NO se siente mejor en un lapso de 20 a 60 minutos siga el plan de la ZONA ROJA

**** SI CONTINÚA CON ESTOS SÍNTOMAS POR UN LAPSO DE 12 A 24 HORAS, LLAME A SU DOCTOR.**

ROJO significa *¡PELIGRO!!!*

*** La medicina no está ayudando**
*** La respiración es difícil y acelerada**
*** La nariz se abre mucho para respirar**
*** No puede hablar bien**

¡ LLAME A UN DOCTOR, YA !!!

¡VAYA CON UN DOCTOR O A UNA SALA DE EMERGENCIAS !
TOME ESTAS MEDICINAS HASTA QUE CONSULTE AL DOCTOR.

Medicina	Dosis	Veces que hay que tomarla
Albuterol/Xopenex		ahora y cada 4 ó 6 horas

Puede repetir esta dosis _____ veces con 20 minutos de intervalo

LLAME AL 911 (EMS) SI: Los labios o las uñas de los dedos están morados, o
Está batallando para respirar, o
No se siente o se ve mejor en un lapso de 20 a 30 minutos

Recomendaciones del médico para los Días de Alerta Para la Calidad Del Aire: (Check one)
□ Ejercicio seguin lo tolerado □ Ninguna actividad vigorosa al aire libre □ Otro _____

Recomendaciones del médico para autoadministración de las medicinas: (Check one)
□ He instruido a _____ (nombre del estudiante) sobre la manera adecuada de usar sus medicinas. En mi opinión profesional, se debe permitir a el/ella, traer y autoadministrarse las medicinas arriba mencionadas, mientras está en las propiedades de la escuela o en eventos relacionados a la escuela.

□ En mi opinión profesional NO se debe permitir a_____(nombre del estudiante), traer y autoadministrarse su medicina (s) para el asma, mientras está en las propiedades de la escuela o en eventos relacionados a la escuela.

Nombre del Proveedor del Cuidado de la Salud en letra de molde	Firma del Proveedor del Cuidado de la Salud	Teléfono	Fecha
_____	_____	_____	_____

Yo, _____ estoy de acuerdo con las recomendaciones del médico de mi hijo(a) anotadas arriba, y autorizo que mi hijo(a) reciba tal medicina(s) como se indica. También autorizo que mi hijo(a) sea fotografiado para propósitos de identificación, y para que el médico de mi hijo(a) comparta información verbal o escrita con la enfermera de la escuela, durante este año escolar.

_____ _____
Firma del padre (madre)/ tutor Fecha

_____ _____ _____
Teléfono de Casa Teléfono de Trabajo Teléfono de Celular

ADAPTADO DE: La Iniciativa Global Contra el Asma (Publicación NIH No. 96-3659C. dic. 1995) y el Christus Santa Rosa Children's Hospital y el Centro del Barrio, San Antonio

Copia Blanca: Paciente Copia Amarilla: Paciente o Escuela Copia Rosa: Médico

Special Olympics Texas

Youth Unified Partner (Under 18)

This form must be completed before any Youth/Unified Partner participates in a Special Olympics activity.

Part 1 - General Information (please print)

DELEGATION: _____ CONTACT: _____

First: _____ Middle: _____ Last: _____

Registered Address: _____ City: _____, TX Zip Code: _____

Gender: O Female O Male DOB: _____ Age: _____ School: _____

Parent/Guardian: _____ Day Phone: _____

E-mail: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Medical History (Please list all allergies and medical conditions): _____

_____

Part 2 - Special Olympics Release and Waiver of Liability

- In consideration of participating in Special Olympics Unified Sports®, I represent I understand the nature of the event and I am qualified, in good health, and in proper physical condition to participate in Unified Sports® events. I fully understand the event involves risks of serious bodily injury which may be caused by my own actions or inactions, by the actions of others participating in the event, or by conditions in which the event takes place. I fully accept and assume all such risks and all responsibility for losses, costs, and/or damages. I acknowledge at any time I feel the event conditions are unsafe, I will discontinue participation immediately.

- If during my participation in Special Olympics activities, I should need emergency medical treatment and I am not able to give my consent for or make my own arrangements for treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

- I release, indemnify, covenant not to sue, and hold harmless Special Olympics, its administrators, directors, agents, officers, volunteers, employees, and other Unified Sports® participants, and sponsors, advertisers, and if applicable, any owners and lessors of premises on which the activity takes place from all liability, any loses, claims (other than that of the medical accident benefit), demands, costs, or damages I may incur as a result of participation in Unified Sports® events and further agree if despite this "Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement", I or anyone on my behalf, makes a claim against any of the Releases, I will indemnify, save, and hold harmless each of the Releases from any litigation expenses, attorney fees, loss, liability, damage or cost which may incur as a result of such claim.

-I have read and agree to the correct code of conduct which refers to the volunteer position I am applying for (ex: Coaches Code of Conduct, Volunteer Code of Conduct, Unified Code of Conduct, Code of Conduct Compliance Policy etc.)

- I, the Parent/Guardian of this youth volunteer, hereby give my permission for this youth volunteer to participate in Special Olympics games, training, recreation programs and physical activity program. By signing, I agree to the provisions of this release.

- I understand the nature and risk of concussion and head injuries, including the risks of continuing to play after concussion or head injury. I acknowledge that Special Olympics has a concussion awareness and safety recognition policy that may require an athlete/partner to seek medical attention from a medical professional in the event of a suspected concussion. Any athlete/partner suspected of sustaining a concussion will not be permitted to return to Special Olympics sports activities until written medical clearance is provided and at least 7 days have passed since the date of the suspected injury. I further acknowledge that additional information regarding concussions may be found on the Centers for Disease Control Heads Up website at http://www.cdc.gov/headsup/youthsports/index.html

X _____

Guardian Signature *Print Name* *Date*

Part 3 - HOD/Head Coach Reference

By signing, I confirm the following: I know _____ (Name of Applicant) in either a personal or professional capacity. I am at least 18 years of age and am not a legal guardian or relative of the applicant. I am not aware of any reason the applicant should not be permitted to volunteer on behalf of Special Olympics. I do not possess any information which would cause me to believe the applicant would pose any undue risk to Special Olympics Athletes or others who participate in Special Olympics.

_____ _____

HOD/Head Coach Signature Date

Please submit application to your local head of delegation/head coach.

www.sotx.org

Special Olympics Texas

ATHLETE/UNIFIED PARTNER CODE OF CONDUCT PLEDGE

Special Olympics is committed to the highest ideals of sport and expects all athletes and unified partners to honor sports and Special Olympics. All Special Olympics athletes and unified partners agree to the following code:

SPORTSMANSHIP

I will practice good sportsmanship. I will act in ways which bring respect to me, my coaches, my team and Special Olympics. I will not use bad language. I will not swear or insult other people. I will not fight with other athletes, coaches, volunteers or staff.

TRAINING AND COMPETITION

I will train regularly. I will learn and follow the rules of my sport. I will listen to my coaches and the officials and ask questions when I do not understand. I will always try my best during training, divisioning and competitions. I will not "hold back" in preliminary competition to get into an easier final competition division.

RESPONSIBILITY FOR MY ACTIONS

I will not make inappropriate or unwanted physical, verbal or sexual advances on others. I will not smoke in non-smoking areas. I will not drink alcohol or use illegal drugs at Special Olympics events. I will not take drugs for the purpose of improving my performance. I will obey all laws and Special Olympics rules, the International Federation and the National Federation / Governing Body rules for my sport(s).

I understand if I do not obey this Code of Conduct, I will be subject to a range of consequences determined by Special Olympics Texas.

Special Olympics Texas – New Braunfels
2090 North IH 35 Suite 5122, New Braunfels, TX 78130 **Phone** 512.788.3243
Facebook www.facebook.com **Twitter** @SOTexas www.SpecialOlympicsTexas.org

Special Olympics Texas

I understand if I do not obey this Code of Conduct, I will be subject to a range of consequences determined by Special Olympics Texas.

_____	_____
Athlete's/ Unified Partner's Signature	Date
_____	_____
Parent/Guardian Signature	Date
_____	_____
Head of Delegation	Date

Upon entering Special Olympics Texas as an athlete/unified partner of the organization, the coach should review and have the athlete/unified partners sign the form (if possible). At that time, the coach should explain what the consequences are of the athlete/unified partner not following the Code of Conduct. The Code of Conduct Agreement needs to be signed only once while the athlete/unified partner participates with any given team. If the athlete/unified partner changes teams, the Code of Conduct should be reviewed with the new coach, consequences explained and the Code of Conduct Agreement signed again. The Athlete/Unified Partner Code of Conduct Agreement should be kept on file by the head coach or head of delegation.

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2090 North IH 35 Suite 5122, New Braunfels, TX 78130 **Phone** 512.788.3243
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Special Olympics
Texas

Special Olympics Texas Parent/Guardian Code of Conduct

Special Olympics Texas (SOTX) is committed to the highest ideals of sport and expects all parents and guardians to honor sport and Special Olympics Texas. All Special Olympics parents and guardians agree to observe the following code of conduct:

RESPONSIBILITIES

- Any concerns will be brought to the attention of the **HOD,** not the coaches**,** in a respectful, courteous manner.
- I will make sure my athlete/partner will attend all practices and competitions, (unless other arrangements have been made) and will arrive on time.
- I will ensure a positive experience for my athletes/partners/coaches.
- I will remember that athletes/partners/coaches are participating for their enjoyment.

RESPECT FOR OTHERS

- I will not use offensive language, nor will I harass coaches, other parents
- I will remember that athletes learn best by example, and I will appreciate good performance and skillful plays by all participants.
- I will respect the rights, dignity and worth of all people involved in the games, regardless of their gender, ability, religion, sexual orientation or cultural background.

ENSURE A POSITIVE EXPERIENCE

- I will encourage athletes to play according to the rules and to settle disagreements without resorting to hostility or violence.
- I will provide positive comments that motivate and encourage all participants.

ACT APPROPRIATELY AND TAKE RESPONSIBILITY FOR MY ACTIONS

- I understand that Special Olympics Texas has a ZERO TOLERANCE POLICY for drinking, drug use and physical/verbal acts of aggression during all Special Olympics practices, games and events. I also understand that any parent, guardian or caregiver who fails to comply with this policy will be asked to immediately leave the practice facility or competition venue.
- I understand that parents and guardians are expected to refrain from challenging coaches' decisions regarding athletes/partners/coaches' positions.

Special Olympics Texas

CONSEQUENCES

Failure to comply with the Special Olympics Texas Parent/Guardian Code of Conduct may result in:

- The parent or guardian being asked to no longer attend Special Olympics Texas events.
- The parent or guardian being asked to leave the practice facility or competition venue..

_____ _____

Parent/Guardian Signature Date

_____ _____

Head of Delegation Signature Date

Upon entering Special Olympics Texas as an Parent of the organization, the coach should review and have the parent sign the form (if possible). At that time, the coach should explain what the consequences are of the parents not following the Code of Conduct. The Code of Conduct Agreement needs to be signed only once while the parent participates with any given team. If the parent changes teams, the Code of Conduct should be reviewed with the new coach, consequences explained and the Code of Conduct Agreement signed again. The Parent Code of Conduct Agreement should be kept on file by the head coach or head of delegation.