Silsbee ISD – Athletic Department

NEW Policy: Temporary Athletics Physical Policy for 2020-2021 School Year

Please read carefully the following information and instructions about required forms for sports, band, cheer and drill team participation. Please keep all completed forms for now. Coaches will collect the forms at a later date.

Physical Examination from healthcare provider:

- **Pertaining to incoming 7th graders:** Students that are incoming 7th graders for the 2020-2021 school year, and are planning to participate in athletics, are required to get a Physical Examination. This must be completed prior to any participation.
- **Pertaining to 8th – 12th graders that have never participated before:** Students that have never participated in middle school or high school athletics, band, cheer, and/or drill team, and have plans to participate in the 2020-2021 school year and do not have a physical examination on file in the SISD athletic department, are required to get a Physical Examination from a medical provider of their choice. This must be completed prior to any participation.
- **Pertaining to all others:** Students that have participated at some time during middle school and/or high school and has a physical on file he/she is not required to get another physical unless the student/parent checks yes to any question #1 through #6 on the medical history form.

Medical history Form:

- **Pertaining to all incoming 7th – 12th graders:** All incoming 7th – 12th graders that will be student athletes and/or members of band, drill team, and cheer must complete the medical history form for 2020-2021.
- **Pertaining to all incoming 7th – 12th graders – Parents and students please Sign the form:** Please make sure the medical history form is signed by both parent/guardian and student
- **Pertaining to all incoming 7th – 12th graders - Note changes to the Medical History Form:** **On the Medical History Form there is a check box added for a voluntary electrocardiogram (ECG).** If this box is checked, it is the responsibility of the parent/guardian to ask the healthcare provider of choice for a ECG test. This test will be at the expense of the parent/guardian. It is the responsibility of the parent/guardian to notify proper school personnel of any abnormal findings that may excluded the student form participating in any extracurricular activity.

Online Forms:

- **Pertaining to all incoming 7th – 12th graders:** All incoming 7th – 12th graders that will be student athletes and/or members of band, drill team, and cheer must complete the online forms for 2020-2021. This must be completed prior to any participation
- **New transfer student to the district:** If the student has recently moved into Silsbee ISD you may not be in our athletic "Rank One" electronic system, and online forms completion is not possible until the student is entered into the system. If this is the case please notify the Athletic Secretary.
- **Online forms Address:** https://silsbeeisd.rankonesport.com/New/NewInstructionsPage.aspx
  - **Click "Proceed to online forms" at the bottom of the page**
  - **Click "Continue as guest"**
  - **Click "Athletic Participation Form"**
  - **Complete the entire form, leave nothing blank**

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?	☐	☐
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	

		Yes	No
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 ______________________

SILSBEE ISD - PREPARTICIPATION PHYSICAL EVALUATION - PHYSICAL EXAMINATION

STUDENT'S NAME: ______________________________ SEX _____ AGE _____ DATE OF BIRTH: ____________

HEIGHT ________ WEIGHT ________ PULSE _______ BP ________/________ (________/________, ________/________)

BRACIAL BLOOD PRESSURE WHILE SITTING

VISION: R 20/________ L 20/________ CORRECTED VISION: ☐ YES ☐ NO 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. 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/mathes.**

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes / Ears / Nose/ Throat		
Lymph Nodes		
Heat-Auscultation of the heart in supine position		
Heart-Auscultation of the heart standing position		
Heart-Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Margan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)		

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

ELECTROCARDIOGRAM – ***ECG testing is not required unless:*** *[1] the parent/guardian checks the box on the UIL medical history form indicating they choose to have additional cardiac screening or, [2] if it is deemed medically necessary by the physician/practitioner.* ***All expenses are the responsibility of the parent/guardian.***

OPTIONAL - ELECTROCARDIOGRAM (ECG) results:

☐ Negative – No abnormalities identified

☐ Positive - Pediatric Cardiologists referral required

ECG Comments: ______________________________

X ______________________________ ______/______/______

Physician / Practitioner Signature *Date of ECG*

CLEARANCE: *Physician / Practitioner please check appropriate box below and add additional comments as needed.*

☐ CLEARED WITH NO RESTRICTIONS

☐ CLEARED AFTER COMPLETING EVALUATION /REHABILITATION FOR: ______________________________

____

☐ NOT CLEARED FOR: ______________________ REASON: ______________________

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 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*

____

Street Address *City* *Zip*

____

Business Phone Number Physician / Practitioner

X ______________________________

Signature of Physician / Practitioner

Office Stamp: