

Granbury ISD 2021-2022 Pre-Participation Physical Evaluation

Student Name: _____ Date of Birth: _____ Age: _____ Grade in 2021-2022: _____ Sex: M F

These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event. Explain "YES" answers on a separate page. Circle questions you do not 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 -- Please answer ALL questions --

- 1. Have you had a medical illness or injury since your last checkup 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 channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?
- Have you had a severe viral infection (ex: 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? Please explain.
- 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 (ex: 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 (ex: 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? (ex: 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?
- 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 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?

EXPLAIN "YES" ANSWERS HERE (attach additional pages if necessary)

Height _____ Weight _____ Pulse _____

BP _____ / _____ (_____ / _____ ; _____ / _____)
(brachial blood pressure while sitting)

Vision R 20/ _____ L 20/ _____ Corrected: Yes No Pupils: Equal Unequal

MEDICAL NORMAL ABNORMAL FINDINGS INITIALS

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
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)			

MUSCULOSKELETAL NORMAL ABNORMAL FINDINGS INITIALS

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

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.

Signature _____

Date of Examination _____

Name (print/type) _____

Address _____

Phone Number _____

FOR SCHOOL USE ONLY:
Printed Name: Rankin / Rhodes Signature: _____ Date: _____ Reviewed this Medical History Form

Granbury ISD 2021-2022 Travel Form

Student's Name (as listed in Skyward Family Access): _____

Home Address: _____ City: _____ Zip: _____

Male Female Date of Birth: _____ Age: _____ Grade in 2021-2022: _____

Sport(s)/Activities: _____

CONTACT INFORMATION

PARENT/GUARDIAN NAME: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT/GUARDIAN NAME: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

An electrocardiogram (ECG) is not required. By checking the box below, 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.

Yes, I elect to obtain an ECG for my student, I understand that he/she will not be able to participate until I provide a doctor's clearance note.

PARENT/GUARDIAN'S PERMIT

- 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, Licensed Athletic Trainer, nurse, hospital, 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.
- 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.
- If applicable, I provide consent to allow my son or daughter to participate in the 2021 GISD Athletic Physical Day and allow them to receive their required physical examination from the available licensed physicians and staff who are present during the Athletic Physical Day.



PARENT/GUARDIAN NAME (PRINT): _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____