# Granbury ISD 2023-2024 Pre-Participation Physical Evaluation

**Student Name:** ______________________________ **Date of Birth:** ______________ **Age:** _______ **Grade in 2023-2024:** _______ **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 unexplained 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 (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**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 20. Are you missing a testicle? |
| ☐ | ☐ | 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 |
|---|---|---|---|
| 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 |
|---|---|---|---|
| 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

This form must be on file prior to participation in any practice, scrimmage, performance or contest before, during, or after school.

# Granbury ISD 2023-2024 Travel Form

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

Home Address: ______________________________ City: ______________ Zip: ________

☐ Male ☐ Female Date of Birth: ______________________ Age: ________ Grade in 2023-2024: ________

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: ______________

## OPTIONAL ECG CARDIAC SCREENING

** Please read the following information regarding the optional ECG Cardiac Screening and understand your responsibility prior to selecting yes. **

**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.
- 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.
- 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 2022 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:*** ______________________________