

## **CHECK LIST FOR ATHLETIC PAPERWORK**

All paperwork must be completed before participating in after school athletics

### **7<sup>th</sup> and 8<sup>th</sup> grade athletes filling out paperwork for the first time:**

\_\_\_\_ **Notarized Parent Approval form** (may be signed by principal instead of being notarized)

\_\_\_\_ Completed **Insurance form** and **\$35** made payable to Johnston M.S.

Or

**Waiver** – You may obtain an insurance waiver from your coach. **You must have a photo ID and proof of insurance.** All waivers must be notarized or signed by a principal.

\_\_\_\_ **Medical History** - The student and a parent/guardian must fill out the Medical History form completely before seeing the Doctor. Be sure to explain all 'yes' answers in the space provided, sign and date prior to seeing the Doctor.

\_\_\_\_ **Current Physical** filled out on an HISD form. It must be signed by a licensed physician and turned in every year. A physical is good year to date. Make sure the Doctor's address and phone number is included on the form.

\_\_\_\_ Xerox copy of **Birth Certificate**

### **Returning 8<sup>th</sup> grade athletes:**

\_\_\_\_ **Parent Approval form**

\_\_\_\_ Completed **Insurance form** and **\$35** made payable to Johnston M.S.

Or

**Waiver** – You may obtain an insurance waiver from your coach. **You must have a photo ID and proof of insurance.** All waivers must be notarized or signed by a principal.

\_\_\_\_ **Medical History** - The student and a parent/guardian must fill out the Medical History form completely before seeing the Doctor. Be sure to explain all 'yes' answers in the space provided, sign and date prior to seeing the Doctor.

\_\_\_\_ **Current Physical** filled out on an HISD form. It must be signed by a licensed physician and turned in every year. A physical is good year to date. Make sure the Doctor's address and phone number is included on the form.

## ***Student Accident/Athletic Insurance***

**Available at the reduced cost of \$35.00 per athlete, per school year!**

If your child/children are covered on another medical plan, you then have the option to either purchase the additional insurance, or waive HISD's Athletic Insurance fee by doing to following:

- Be the parent or legal guardian of the athlete.
- Show proof of medical insurance on your child/children.
- Show a valid government or state-issued photo identification or driver's license.

***Note: Since original signatures are required, Insurance waivers cannot be faxed.***

***ALL ATHLETES MUST BE INSURED TO PARTICIPATE IN ANY ATHLETIC ACTIVITY!***

**HOUSTON INDEPENDENT SCHOOL DISTRICT  
ATHLETIC DEPARTMENT**

**PARENT'S APPROVAL FOR PARTICIPATION IN ATHLETICS AND EMERGENCY MEDICAL AUTHORIZATION**

I hereby certify that \_\_\_\_\_ has my approval to play at home or away from  
(Student)

home on the athletic teams of the \_\_\_\_\_ Middle/High School, grade \_\_\_\_\_, as  
follows: (School)

Baseball/Basketball/Cheerleader/Cross-Country/Football/Golf/Soccer/Softball/Swimming/Tennis/Track/Volleyball/Wrestling  
(Parent will check sports or events he/she does not approve.)

I understand and agree that the HISD Board of Education and the employees and agents of HISD assume no responsibility or liability for any accident or injury as a result of any aspect of participation in the sports listed above.

I understand and acknowledge that participation in the above-listed sports creates the potential for receiving an injury. With the knowledge of this potential risk of injury, I am giving my son/daughter permission to participate in athletics and accept full responsibility for this decision.

In the event of an injury, I hereby grant permission to school officials and employees to render, secure, and authorize necessary medical treatment.

I understand that medical expenses for injuries will be paid only according to the HISD Department of Athletics rules, and such payments do not waive HISD's general immunity or create any liability for injuries or damages.

My insurance company is \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

(both parents, if possible)

Date \_\_\_\_\_ Telephone \_\_\_\_\_ Home Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signed \_\_\_\_\_  
(Parent or Guardian) (Parent or Guardian)

Date \_\_\_\_\_ Telephone \_\_\_\_\_ Home Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signed \_\_\_\_\_  
(Parent or Guardian) (Parent or Guardian)

I certify that this release was signed in my presence.

\_\_\_\_\_  
Student Social Security Number

\_\_\_\_\_  
Principal or Notary (no stamped signature)  
(first year of participation requirement)

PLACE OF EMPLOYMENT (both parents, if possible)

(Father) (Mother)  
Name of Firm \_\_\_\_\_ Name of Firm \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

NOTE TO THE COACH: You must have a completed form before the student may participate in or practice for any sport. File the original in the office of the school attended. You must file a copy every school year. A notarized copy or a copy signed by the parents in the presence of the principal must be filed for the first year of participation at the school the student attends. Thereafter, a parent approval signed by the parents or parent must be submitted before the student may participate.

**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 times? _____ concussion?			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had 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"/>	What was the longest time between periods in the last year? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>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.</b>		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</b>		
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\***

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>INITIALS*</b>
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.

**Confirmation of Understanding of  
Purpose of the UIL Pre-participation Physical Exams**

I \_\_\_\_\_ am aware that my child/ward, \_\_\_\_\_, will attend an event at Reliant Stadium on May 22, 2010 ("the event"). The event is sponsored by The Methodist Hospital System ("TMHS") where screening physical exams for the sole purpose of clearing students for participation in athletic programs at their school will be performed by volunteer healthcare providers. By signing this form, I am confirming my understanding and agreeing to the following:

- This is **NOT** a comprehensive physical exam and does not take the place of routine medical care; this examination/testing is **for clearance before participation in athletic activities ONLY**;
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- My child may need additional testing before s/he can be cleared for participation in athletic activities and **it is my sole responsibility to obtain such additional testing or medical care**; if it is determined that my child needs additional medical treatment, I will be notified of any such recommendation via Certified Mail Return Receipt Requested at the following **current mailing address**:

ENTER ADDRESS HERE \_\_\_\_\_

- Additional non-invasive tests, such as an EKG and/or echocardiogram, may be available and performed at the event for my convenience; **I consent to any and all additional non-invasive testing as deemed necessary by the screening provider during the event without additional notification to me prior to the testing**;
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event; and
- As a convenience and courtesy only, TMHS will act as a repository for the record of my child's physical; no patient relationship or fiduciary duty is created by the possession of these records by TMHS.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

## RELEASE FROM LIABILITY AND INDEMNIFICATION

I hereby release, waive, discharge and covenant not to sue any providers or The Methodist Hospital System ("TMHS") and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the event.

Additionally, I agree to indemnify TMHS and any providers for any causes of action my child or his/her representative may bring.

I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in this Release. I have had the opportunity to have this Release and Indemnification reviewed by an attorney of my choice.

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Parent/Guardian's Signature

Date