



PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY



This **MEDICAL HISTORY FORM** must be completed annually by parent (or guardian) and student in order for the student to participate in **TAPPS** 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 NAME (PRINT): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____ PARENT CELL PHONE: _____

SCHOOL: _____ GRADE LEVEL: _____

PERSONAL PHYSICIAN: _____

PHYSICIAN PHONE: _____

In case of emergency contact:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	YES	NO
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any family member or relative died of heart problems before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member been diagnosed with Long QT Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has any family member been diagnosed with Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had a severe viral infections (myocarditis, mononucleosis, etc) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever experienced a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had numbness in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you currently taking any prescription or nonprescription medications or inhalers?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever been dizzy before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever become ill after exercising or working in the heat?	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

- 32. Have you ever had any problems with your eyes or vision? YES NO
- 33. Have you ever gotten unexpectedly short of breath with exercise? YES NO
- 34. Do you have asthma? YES NO
- 35. Do you have seasonal allergies that require medical treatment? YES NO
- 36. Do you use any special protective or corrective equipment? YES NO
- 37. Have you ever had a sprain, strain or swelling after injury? YES NO
- 38. Have you ever broken or fractured any bones? YES NO
- 39. Have you ever dislocated any joints? YES NO
- 40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? YES NO

If yes, please check the appropriate box and explain on separate sheet of paper.

- | | | | | |
|--------------------------------|------------------------------------|---------------------------------|-------------------------------------|-------------------------------|
| Head <input type="checkbox"/> | Shoulder <input type="checkbox"/> | Wrist <input type="checkbox"/> | Thigh <input type="checkbox"/> | Foot <input type="checkbox"/> |
| Neck <input type="checkbox"/> | Upper Arm <input type="checkbox"/> | Hand <input type="checkbox"/> | Knee <input type="checkbox"/> | |
| Back <input type="checkbox"/> | Elbow <input type="checkbox"/> | Finger <input type="checkbox"/> | Shin/ Calf <input type="checkbox"/> | |
| Chest <input type="checkbox"/> | Forearm <input type="checkbox"/> | Hip <input type="checkbox"/> | Ankle <input type="checkbox"/> | |

- 41. Do you want to weigh more or less than you do now? YES NO
- 42. Do you lose weight regularly to meet weight requirements for you Extra-Curricular Activities? YES NO
- 43. Do you feel stressed out? YES NO
- 44. Have you been diagnosed with or treated for Sickel Cell Trait or Sickel Cell Disease? YES NO

Females Only

- 45. When was your first menstrual period? _____
- 46. When was your most recent menstrual period? _____
- 47. How much time elapses from the start of one period to the start of another? _____ days
- 48. How many periods have you had in the last year? _____
- 49. What was the longest time between period in the last year? _____ days

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of accident still remains. Neither the **Texas Association of Private and Parochial Schools**, 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 illness, 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, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, in 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 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 and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.

STUDENT SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN NAME (PRINT): _____

PARENT SIGNATURE: _____ DATE: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____