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?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
3. Have you ever had surgery?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
5. Have you ever had chest pain during or after exercise?	☐	☐
6. Do you get tired more quickly than your friends during exercise?	☐	☐
7. Have you ever experienced racing of your heart or skipped heartbeats?	☐	☐
8. Have you ever had high blood pressure?	☐	☐
9. Have you ever had high cholesterol?	☐	☐
10. Have you ever been told you have a heart murmur?	☐	☐
11. Has any family member or relative died of heart problems before age 50?	☐	☐
12. Has any family member or relative died of sudden unexpected death before age 50?	☐	☐
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	☐	☐
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	☐	☐
15. Has any family member been diagnosed with Long QT Syndrome?	☐	☐
16. Has any family member been diagnosed with ion channelpathy (Brugada syndrome, etc.)?	☐	☐
17. Has any family member been diagnosed with Marfan's syndrome?	☐	☐
18. Have you had a severe viral infections (myocarditis, mononucleosis, etc.) in the past year?	☐	☐
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
20. Have you ever had a head injury or concussion?	☐	☐
21. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
22. Have you ever experienced a seizure?	☐	☐
23. Have you ever had numbness in your arms, hands, legs or feet?	☐	☐
24. Have you ever had a stinger, burner or pinched nerve?	☐	☐
25. Are you missing any paired organs?	☐	☐
26. Are you presently under a doctor's care?	☐	☐
27. Are you currently taking any prescription or nonprescription medications or inhalers?	☐	☐
28. Do you have any allergies?	☐	☐
29. Have you ever been dizzy before or during exercise?	☐	☐
30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	☐	☐
31. Have you ever become ill after exercising or working in the heat?	☐	☐

TEXAS ASSOCIATION OF PRIVATE AND PAROCHIAL SCHOOLS

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION

STUDENT'S NAME _____ SPORT(S):_____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % OF BODY FAT:_____

PULSE: _____ BLOOD PRESSURE: ___/___ (___/___,___/___)

VISION R 20/_____L 20/_____CORRECTED: Y N Pupils: EQUAL_____UNEQUAL _____

In keeping with the requirements of the Texas Association of Private and Parochial School, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation each year of high school.

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)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
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: _____

Provider Name: _____Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

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

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

Head	☐	Shoulder	☐	Wrist	☐	Thigh	☐	Shin/ Calf	☐
Neck	☐	Upper Arm	☐	Hand	☐	Knee	☐		
Back	☐	Elbow	☐	Finger	☐	Foot	☐		
Chest	☐	Forearm	☐	Hip	☐	Ankle	☐		

41. Do you want to weigh more or less than you do now?	☐	☐
42. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities?	☐	☐
43. Do you feel stressed out?	☐	☐
44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	☐	☐

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: _____

CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way a student's brain normally functions
- Can occur during practice or contests in any sport
- Can occur in activities both associated and not associated with the school
- Can occur even if the student has not lost consciousness
- Can be serious even if a student has just been "dinged" or had their "bell rung"

Are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, one or more of the following symptoms may become apparent. The student may not "feel right" soon after, a few days after or even weeks after the injury event.

Headache	"Pressure" in the head	Nausea	Vomiting
Balance problems	Dizziness	Blurry Vision	Double Vision
Sensitivity to Light	Sensitivity to Noise	Confusion	Memory Problems
Difficulty paying attention	Feeling sluggish, hazy, foggy or groggy		

If you have concerns regarding any of the above symptoms, your doctor should be consulted for further information and/or examination. Your physician or medical professional can best determine your student's physical condition and ability to participate in athletics.

What should students do if they believe that they or someone else may have a concussion?

- Students should immediately notify their coach or school personnel.
- Student should be examined by appropriate medical personnel of the parent's choosing. The medical provider should be trained in the diagnosis and treatment of concussions
- If no concussion is diagnosed, the student shall be cleared to return to athletic participation.
- If a concussion is diagnosed, the school protocol for return to play from a concussion shall be enacted. Under no circumstances shall the student be allowed to return to practice or play without the approval of a licensed medical provider trained in the treatment of concussions.

I have reviewed the above material. I understand the symptoms and warning signs of CONCUSSIONS. Additional information is available on the Health and Safety page at www.tapps.biz. All concussions should be reported to the school as soon as possible. Previous concussions should be reported on the Medical History form to allow the medical practitioner the best information possible when conducting the annual physical examination.

Parent Signature / Date: _____

Student Signature / Date: _____

CONCUSSIONS – Don't hide it. Report it. Take time to recover.