

Last Name	First Name	MI	Student ID	Grade	Date of Birth	Sex	Sports ( List All Participating In)	
Street Address (No P.O. Boxes)			City			Zip		Home Phone
Guardian's Name		Employer		Cell Phone		Work Phone		Relationship to Student
Guardian's Name		Employer		Cell Phone		Work Phone		Relationship to Student
Secondary Emergency Contact Name				Cell Phone		Home Phone		Relationship to Student

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL, INCLUDING AN ATHLETIC PERIOD.

<p>1. Have you had a medical illness or injury since your last check up or sports physical? <span style="float: right;">YES NO</span></p> <p>2. Have you been hospitalized overnight in the past year? <span style="float: right;">YES NO</span></p> <p>3. Have you ever had surgery? <span style="float: right;">YES NO</span></p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <span style="float: right;">YES NO</span></p> <p>What Age? _____</p> <p>What was the diagnosis? _____</p> <p>Have you ever passed out during or after exercise? <span style="float: right;">YES NO</span></p> <p>Have you ever had chest pain during or after exercise? <span style="float: right;">YES NO</span></p> <p>Do you get tired more quickly than your friends do during exercise? <span style="float: right;">YES NO</span></p> <p>Have you ever had racing of your heart or skipped heartbeats? <span style="float: right;">YES NO</span></p> <p>Have you had high blood pressure or high cholesterol? <span style="float: right;">YES NO</span></p> <p>Have you ever been told you have a heart murmur? <span style="float: right;">YES NO</span></p> <p>Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <span style="float: right;">YES NO</span></p> <p>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)? <span style="float: right;">YES NO</span></p> <p>Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <span style="float: right;">YES NO</span></p> <p>Has a physician ever denied or restricted your participation in sports for any heart problems? <span style="float: right;">YES NO</span></p> <p>4. Have you ever had a head injury or concussion? <span style="float: right;">YES NO</span></p> <p>Have you ever been knocked out, become unconscious, or lost your memory? <span style="float: right;">YES NO</span></p> <p>If yes, how many times? _____</p> <p>When was the last concussion? _____</p> <p>How severe was each one? (Explain below)</p> <p>Have you ever had a seizure? <span style="float: right;">YES NO</span></p> <p>Do you have frequent or severe headaches? <span style="float: right;">YES NO</span></p> <p>Have you ever had numbness or tingling in your arms, hands, legs, or feet? <span style="float: right;">YES NO</span></p> <p>Have you ever had a stinger, burner, or pinched nerve? <span style="float: right;">YES NO</span></p> <p>5. Are you missing any paired organs? <span style="float: right;">YES NO</span></p> <p>6. Are you currently under a doctor's care for a specific illness, injury or medical condition? <span style="float: right;">YES NO</span></p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills? <span style="float: right;">YES NO</span></p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <span style="float: right;">YES NO</span></p> <p>Do you have seasonal allergies that require medical treatment? <span style="float: right;">YES NO</span></p> <p>9. Have you ever been dizzy during or after exercise? <span style="float: right;">YES NO</span></p>	<p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <span style="float: right;">YES NO</span></p> <p>11. Have you ever become ill from exercising in the heat? <span style="float: right;">YES NO</span></p> <p>12. Have you had any problems with your eyes or vision? <span style="float: right;">YES NO</span></p> <p>13. Have you ever gotten unexpectedly short of breath with exercise? <span style="float: right;">YES NO</span></p> <p>Have you ever been diagnosed with asthma? <span style="float: right;">YES NO</span></p> <p>Within the past year, have you experienced an asthma attack? <span style="float: right;">YES NO</span></p> <p>Are you prescribed an inhaler? <span style="float: right;">YES NO</span></p> <p>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)? <span style="float: right;">YES NO</span></p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <span style="float: right;">YES NO</span></p> <p>Have you broken or fractured any bones or dislocated any joints? <span style="float: right;">YES NO</span></p> <p>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <span style="float: right;">YES NO</span></p> <p>If yes, check appropriate box and explain below.</p> <p><input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Thigh <input type="checkbox"/> Ankle</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Finger <input type="checkbox"/> Knee <input type="checkbox"/> Foot</p> <p><input type="checkbox"/> Back <input type="checkbox"/> Upper Arm <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Shin/Calf</p> <p>16. Are you unsatisfied with your current weight? <span style="float: right;">YES NO</span></p> <p>17. Do you feel stressed out? <span style="float: right;">YES NO</span></p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <span style="float: right;">YES NO</span></p> <p>19. Do you have any other medical conditions not previously mentioned (for example, diabetes, thyroid disease, immune disorders, bleeding disorder, etc)? <span style="float: right;">YES NO</span></p> <p>20. Have you tested positive for Covid-19? <span style="float: right;">YES NO</span></p> <p><b>MALES ONLY</b></p> <p>21. Are you missing a testicle? <span style="float: right;">YES NO</span></p> <p>Do you have any testicular swelling or masses? <span style="float: right;">YES NO</span></p> <p><b>FEMALES ONLY</b></p> <p>22. When was your first menstrual period? _____</p> <p>When was your most recent menstrual period? _____</p> <p>How much time do you usually have from the start of one period to the start of another? _____</p> <p>How many periods have you had in the last year? _____</p> <p>What was the longest time between periods in the last year? _____</p> <p><input type="checkbox"/> An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness form. I understand it is the responsibility of my family to schedule and pay for such ECG.</p> <p>Explain Yes Answers (use another sheet if necessary) _____</p>
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*It is understood that even though protective equipment is worn by the athletes, whenever needed, the possibility of accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs. If, in the judgement 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 such account of such care and treatment of such 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.*

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: \_\_\_\_\_

<p>This Medical History Form was reviewed by:</p> <p>Doctor: _____</p> <p style="text-align: center;">Signature</p>	<p>School Official: _____</p> <p style="text-align: center;">Signature</p>
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**PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_

BP	/	/	/
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brachial blood pressure while sitting

% Body fat (optional) \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected:  Y  N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</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) If indicated			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Marfan's stigmata (arachnodactyly, pectus, excavatum, joint hypermobility, scoliosis)			

**Austin ISD requires that each athlete have an annual physical dated after April 15, 2022**

**CLEARANCE**

- Cleared; Recommendations: \_\_\_\_\_
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- Not cleared for: \_\_\_\_\_

Reason: \_\_\_\_\_

<p>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.</p>	
Name (print/type): _____	Date of Examination: _____
Address: _____	Phone: _____
Signature: _____	SIGNATURE ALSO REQUIRED BELOW MEDICAL HISTORY ON FRONT OF FORM

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.

Name \_\_\_\_\_

PLEASE PRINT

Austin Independent School District  
**EMERGENCY STUDENT INFORMATION CARD**

Sport(s)

Austin ISD policy requires the completion of this permit for participation in athletics.

If, in the judgment of any representative of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school district and any school representative from any claim by any person whatsoever on account of such care and treatment of said student.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (Last, First) \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

School Attending \_\_\_\_\_ Student ID \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian(s) Name \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_

**\*\*Athletics and Cheer Only\*\***

**[austinisd.rankonesport.com](http://austinisd.rankonesport.com)**

Austin ISD Athletic Department has switched over to online forms. You will complete all signatures and paperwork online, with the exception of the medical history and physical exam. Both the online forms and the physical exam must be completed before your student can participate in any practice or game, including the athletic period.

Online forms must be completed by the parent/guardian and student athlete simultaneously.

**INSTRUCTIONS:**

- Go to: **[austinisd.rankonesport.com](http://austinisd.rankonesport.com)** or scan the QR code below
- Enter your students ID number and name as it is shown on their report card
- There are two separate electronic participation forms to complete: Contact Info and UIL forms
- Read, complete, and electronically sign both forms. Student and Parent/Guardian must sign at the same time
- Print a copy of the forms for your records only, if desired. Do not send in hard copies of online materials
- Complete the physical exam with your physician and return both the medical history and physical page along with the emergency card above, to the designated school official



