Austin Independent School District (AISD)

2020 - 2021 PARTICIPATION FORM

School_____

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.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports 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?	☐	☐
What Age? _____		
What was the diagnosis?_____		
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 unexpected death before age 50?	☐	☐
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)?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports 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 the last concussion? _____		
How severe was each one? (Explain below)		
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 currently under a doctor's care for a specific illness, injury or medical condition?	☐	☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?	☐	☐
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐

	YES	NO
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?	☐	☐
Have you ever been diagnosed with asthma?	☐	☐
Within the past year, have you experienced an asthma attack?	☐	☐
Are you prescribed an inhaler?	☐	☐
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)?	☐	☐
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?	☐	☐
If yes, check appropriate box and explain below.		
☐ Head ☐ Chest ☐ Elbow ☐ Hand ☐ Thigh ☐ Ankle		
☐ Neck ☐ Shoulder ☐ Forearm ☐ Finger ☐ Knee ☐ Foot		
☐ Back ☐ Upper Arm ☐ Wrist ☐ Hip ☐ Shin/Calf		
16. Are you unsatisfied with your current weight?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
17. Do you feel stressed out?	☐	☐
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐
19. Do you have any other medical conditions not previously mentioned (for example, diabetes, thyroid disease, immune disorders, bleeding disorder, etc)?	☐	☐
MALES ONLY		
20. Do you have less than two testicles?	☐	☐
21. Do you have any testicular swelling or masses?	☐	☐
FEMALES ONLY		
22. 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?	_____	

☐ **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. I understand it is the responsibility of my family to schedule and pay for such ECG.**

Explain Yes Answers (use another sheet if necessary) _____

_____

_____

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:**_____

This Medical History Form was reviewed by:	
Doctor: _____ Signature	School Official: _____ Signature