CSISD PRE-PARTICIPATION MEDICAL HISTORY/PHYSICAL EXAM *CSISD will not accept physicals dated prior to April 1, 2026

Student's Name	Student's ID Number	School for 26-27	Primary Sport	Sex	26-27 Grade	Date of Birth

STUDENT-PARENT/GUARDIAN SECTION

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.

*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
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?		
	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 ever 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 channelpathy (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 activities for any heart problem?		
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 under a doctor's care?		
7	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?		
8	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
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)?		
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?		
	Do you have asthma?		
	Do you have seasonal allergies that require medical treatment?		
14	Do you use any special protective or corrective equipment or devices that aren't usually for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer for 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, circle appropriate body part and explain below. Head Elbow Hip Neck Forearm Thigh Back Wrist Knee Chest Hand Shin/Calf Shoulder Finger Ankle Upper Arm Foot		
16	Do you want to weigh more or less than you do now?		
	Do you lose weight regularly or 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?		

☐ I choose not to provide written information for Question 19 (below) but will discuss with a medical professional.

Females Only

19 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? _____

Males Only

19 Are you missing a testicle? _____ Do you have any testicular swelling or masses? _____

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.

EXPLAIN 'YES' ANSWERS HERE (attach another sheet if necessary): _____

☐ Optional: An electrocardiogram (ECG) is not required. By marking this box, I choose to obtain an ECG for my student. I understand it is the responsibility of my family to schedule and pay for such an ECG. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form.

-It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the UIL 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 are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL.

X Parent/Guardian signature (*required*) _____ Date _____

X Student signature (*required*) _____ Date _____

MEDICAL EXAMINER SECTION – All grades (7th-12th)

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 in the left column. *Local district policy REQUIRES an annual physical exam.

Height: _____ Weight: _____ Pulse: _____
BP: _____/_____ (_____/_____; _____/_____)
Vision: R-20/_____ L-20/_____ Corrected: Y or N Pupils: Equal/Unequal

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart Auscultation Standing			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

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.

Date of Examination: _____
Name (print/type): _____
Address: _____
Phone Number: _____
Physician's Signature: _____

This form must be on file prior to participation in any practice, scrimmage, performance or contest before, during, or after school.

FOR SCHOOL USE ONLY – This Medical History form was reviewed by:

Printed name _____ Signature _____ Date _____