ASTHMA: Yes / No

Athletic Pre-Participation Screen Form
2013-2014

Galena Park ISD
Department of Athletics
15025 Wallisville Road
Houston, TX 77049
832-386-4330 Phone
832.386.4331 Fax

The contents below are enclosed in this form:

- *Form Guidelines*
- *Student Athlete Insurance*
- *Medical History Form*
- *Physical Examination Form*
- *UIL Steroid Use Letter*
- *Acknowledgement of Rules*
- *General Information*
- *Eligibility Rules*

Vincent Sebo
Athletic Director
Vivian Dancy
Women's Coordinator

Please complete the following (PRINT IN INK):

(To be completed by Student and Parent/Guardian)

Student's Name: _____ (Last) _____ (First) _____ (Middle)

Year of High School Graduation: 20_____ *Grade_____* *Social Security Number:* _____-_____-_____

Date of Birth _____/_____/_____ *Sex*_____ *Student ID #* _____ *State ID#*_____

Address: _____ (Street) _____ (City) _____ (Zip Code)

Parent/ Guardian Information:

*Mother:*_____ *Father:*_____

*(H)*_____ *(H)* _____

*(C)*_____ *(C)*_____

*(W)*_____ *(W)*_____

Insurance Company Name: _____ *Policy/ ID Number:* _____

*Insurance Group Number*_____ *Insurance Phone Number* _____

Personal Physician: _____ *Office Phone:* _____

In case of emergency contact the following (NOT THE PARENT/GUARDIAN):

Name _____ *Relationship*_____

Phone (H) _____ (W) _____ (C) _____

Form Guidelines: *(To be signed by Parent/Guardian)*

Parent / Guardian:

This form consists of information and materials needed for your child to be medically eligible/ released to participate in Galena Park ISD / UIL sponsored activities. This form is designed to determine if the student has developed any condition, which could make it hazardous to participate in an athletic event. The following are important points concerning this form:

- This form must be completed annually. **Student athletes entering grades 7-12 and others indicated by the medical history must take a physical exam by a licensed physician, board certified physician assistant / nurse practitioner.**
- This form must be completed in full with all required signatures, by all student athletes and parents *(or guardian).*
- **Students may not participate in any practice (including athletic periods), scrimmage, tryouts, or competition** until this form is on file in the athletic trainer's office.

If you have any questions concerning this form or other medical questions pertaining to the welfare of your child, please contact the athletic trainer at the following number:

North Shore High School Training Room .....832-386-4330 ext 4371,ext 3782
Galena Park High School Training Room ----------832-386-2800 ext 2855, ext 2854

Student Athlete Insurance Policy:

Parent / Guardian:

The Galena Park ISD has purchased a **limited benefit insurance** policy that covers all student athletes while participating in UIL activities.

The insurance coverage is **"SECONDARY" or "EXCESS"** which is designed to pay those expenses not paid or payable by any other insurance. This means that you will be required to file first with your personal insurance and then after benefits are paid the school insurance company will pay on the remaining balance.

If you want additional coverage for your child, a limited benefit plan may be purchased through the school plan that will provide limited benefits for the student when he / she is not participating in athletic / UIL events. The athletic insurance is not 24-hour accident insurance.

The following is important information concerning the athletic UIL coverage:

1) This policy covers your child only during practice (in-season or off-season), competition, and travel to and from UIL sanctioned activities.
2) This policy is a zero deductible. It is a limited benefit plan. **It will not pay 100 percent of the bills.** It is coordinated with any personal coverage that you may have. Your personal insurance is the primary carrier and the school insurance is the secondary carrier.
3) Any bills not paid by your personal carrier or the school insurance will be the responsibility of the parents / guardians. Parents / Guardians will handle all bills and claims. ***Galena Park ISD is not responsible for the handling or payment of medical bills.***
4) Parents / Guardians must give personal insurance information to the athletic trainer, team or family doctors and all other health care providers in regards to your child's athletic injury.
5) Parents / Guardians must notify the athletic trainer prior to doctor visits or insurance benefits may be forfeited.

I have read the form guidelines and the insurance information cited above and I understand the contents herein.

_____ _____
Parent or Guardian Signature Date

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional)_____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision R 20/_____ L 20/___ Corrected: Y N Pupils: Equal Unequal

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 on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
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			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
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: _____

_____

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.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

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

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

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.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

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 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 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 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 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 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	☐ 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 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?	☐	☐

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? _____

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 IN THE BOX BELOW* (attach another sheet if necessary):

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League 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 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 FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

Athlete Name_____ Date_____

Dear Parent/Guardian,

Galena Park ISD is currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, with the assistance of the Memorial Hermann Sports Medicine team, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed. This test in conjunction with a physical exam and findings will assist the medical team in making decisions on athletes return to activity.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to a local doctor or, to help evaluate the injury. The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to work with Memorial Hermann and their sports medicine team to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The administration, coaching, and athletic training staffs along with Memorial Hermann are striving to keep your child's health and safety at the forefront of the student athletic experience. If you have any further questions regarding this program please feel free to contact us at 832.386.4330.

Sincerely,
Galena Park ISD Sports Medicine Department

I do ___ I do Not___ give permission for my son/daughter to take the ImPACT test.

OVER THE COUNTER MEDICINES

Parent/ Guardian:
Please check YES or NO to the following medications that your child may or may not take. Checking YES will give the Licensed Athletic Trainer permission to dispense those over the counter medications to your child if need.

Anti-Inflammatory: (ex. Ibuprofen, Aleve, Advil).....	☐YES	☐ NO
ACETAMINOPHEN (ex. Tylenol).....	☐YES	☐ NO
PEPTO BISMOL (Upset Stomach).....	☐YES	☐ NO
IMODIUM (Diarrhea).....	☐YES	☐ NO
ANTACID (ex. TUMS)..... ...	☐ YES	☐ NO
COUGH SUPPRESSANT (ex. Cough Drops or Syrup)....	☐YES	☐ NO

Medical Consent to Treat in a Medical Emergency

If, in the judgment of any representatives 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, trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. Your signature gives the authorization that is necessary for the school district, its Licensed Athletic Trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your child.

Parent/ Guardian Signature: _____