



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: _____



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

YES NO

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

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? YES NO
- 42. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities? YES NO
- 43. Do you feel stressed out? YES NO
- 44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? YES NO

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.

SUDDEN CARDIAC ARREST

What is Sudden Cardiac Arrest (SCA)?

Sudden Cardiac Arrest is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is not a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction of the heart's electrical system, causing the heart to stop beating.

How common is Sudden Cardiac Arrest?

While studies differ in the actual rate of occurrence, the American Heart Association information indicates that there are approximately 300,000 SCA events outside hospitals each year in the United States. About 2000 patients under the age of 25 die of SCA each year. Studies now being performed in Texas and other states indicate the occurrence rate for high school age athletes may be greater than this figure.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

Dizziness	Fatigue	Lightheadedness
Extreme tiredness	Shortness of breath	Nausea
Difficulty breathing	Vomiting	Racing or fluttering heartbeat
Chest Pains	Syncope (fainting)	

These symptoms can be confusing and unclear in athletes. Often people confuse these warning signs as physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

For this reason these symptoms are included on the Medical History form provided by TAPPS and required for each student prior to participation in athletic events each year. As parents and student athletes, your truthful answers to these simple questions will assist your medical practitioner when performing the annual physical examination.

What are the risks of participation and playing with these symptoms?

Continued participation brings with it increased risk. This includes playing in practices and games. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just minutes. Most people who experience a SCA die from the event.

While TAPPS does not mandate Cardiac Screening prior to participation, TAPPS and the TAPPS member schools recognize the importance of our students' health and highly recommend discussing screening options with your healthcare provider. Any student who shows signs of SCA should be removed by the parents from play. This includes all athletic activity, practices or contests. Before returning to play, the student should be examined and receive clearance by a licensed health care professional of the parents' choosing.

**I have reviewed the above material. I understand the symptoms and warning signs of SCA.
Additional information is available on the Health and Safety page at www.tapps.biz.**

Parent Signature / Date: _____

Student Signature / Date: _____

Legacy Christian Academy Consent to Treat Form

Name of student: _____
Name of parent(s), guardian(s) or adult(s): _____
Address: _____
Home telephone: _____ Work telephone: _____ Cell telephone: _____
Emergency Contact: _____ Phone Number: _____

Medical Information / History:

Date of Birth: ____ / ____ / ____ Age: _____ Date of last tetanus shot: ____ / ____ / ____

Is your student presently being treated for an injury or sickness or taking any medication: Yes No
If yes, explain: _____

Does your child/youth/adult have, or have they, ever had any of the following? (Please check all that apply.)

Asthma Hay Fever Kidney Disease Diabetes Heart Murmur Seizure Disorders

Please explain: _____

Does your student ever sleepwalk? Yes No Child/Youth/Adult's Blood Type: _____

Does your student have a physical handicap or illness that would prevent him / her from participating in normal rigorous activity?

Yes No If yes, please explain: _____

Family Doctor: _____ Doctor's Telephone: _____

I, _____ am / am not covered by medical insurance.

Insurance Company: _____

Primary Insured: _____

Pre-certification Phone #: _____ Policy #: _____ Group #: _____

Medical Treatment Authorization

I understand that I will be notified in the case of a medical emergency. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event that my student is injured or becomes ill. I authorize Legacy Christian Academy to make emergency medical care decisions on behalf of my student. This may include emergency room treatment, hospitalization, surgery, securing the services of medical personnel, x-rays, and/or medications. I hereby assume responsibility for these costs.

I understand that Legacy Christian Academy will not be responsible for medical expenses incurred solely on the basis of this authorization. I further agree to notify the athletic department in writing of any health changes that would restrict my student's participation in any normal activities. I also understand that the athletic department and designated coaches reserve the right to restrict my student from any activity that they do not feel is within the physical capabilities of my student.

Signature of Parent/Guardian/Adult: _____ Date: ____ / ____ / ____