If you do not know the answer circle the question.         1.Have you had a medical illness or injury since your last check up       YES NO         2. Have you been hospitalized overnight in the past year?       YES NO         3. Have you ever had singer?       YES NO         3. Have you ever had singer?       YES NO         Have you ever had singer?       YES NO         Have you ever passed out during or after exercise?       YES NO         Have you ever passed out during or after exercise?       YES NO         Have you ever based neized with any vur fineds do during exercise?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever been told you have a heart murmar?       YES NO         Have you ever had a severe viral infection (for example, myocarditis or mononucleosis)       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a singer, burmer, or pinched nerve?       YES NO         Have you ever	PREPA s a min unior his articipat tudents leight /ision //isio
If you do not know the answer circle the question.         1.Have you had a medical illness or injury since your last check up       YES NO         or sports physical?       YES NO         2. Have you been hospitalized overnight in the past year?       YES NO         3. Have you ever had surger?       YES NO         3. Have you ever had surger?       YES NO         3. Have you ever passed out during or after exercise?       YES NO         Have you ever passed out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during or after exercise?       YES NO         Have you ever bast out during out after exercise?       YES NO         Have you ever bast out fiftetin (for example, myocarditis or mononucleosi	PREPA s a mir inior his articipa tudents leight //ision l ppear yes/E ye
1.Have you had a medical illness or injury since your last check up       YES NO         2. Have you been hospitalized overnight in the past year?       YES NO         3. Have you ever had surgery?       YES NO         3. Have you ever had grior testing for the heart ordered by a physician?       YES NO         Have you ever had surgery?       YES NO         Have you ever had check pain during or after exercise?       YES NO         Have you ever had check pain during or after exercise?       YES NO         Have you ever had renies of your heart or skipped heartheets?       YES NO         Have you ever had renies of your heart or skipped heartheets?       YES NO         Have you ever had renies of your heart or skipped heartheets?       YES NO         Have you ever had renies of your heart or skipped heartheets?       YES NO         Have you ever had renies of (Brugada syndrome, step), Marfan's syndrome, or other ion channelopaty (Brugada syndrome, step), Marfan's syndrome, or other ion channelopaty (Brugada syndrome, step), Marfan's syndrome, YES NO       Have you ever hear had had injury or concussion?         Have you ever been knocked out, become unconscious, or lost your memory?       YES NO       Have you ever been knocked out, become unconscious, or lost your memory?       YES NO         Have you ever hear had a signary particip and in your arms, hands, legs, or feet?       YES NO       Have you ever had a sizure?         Do you have a seizure?       YES NO<	s a mir unior hig articipa tudents leight //ision l height //ision l heigh
or sports physical?       YES NO       Adv         2. Have you been hospitalized overnight in the past year?       YES NO         Have you ever had prior testing for the heart ordered by a physician?       YES NO         Have you ever had prior testing for the heart ordered by a physician?       YES NO         Have you ever had near testing or after exercise?       YES NO         Have you ever had roin testing or after exercise?       YES NO         Have you ever had roin testing or after exercise?       YES NO         Have you ever had roin testing of the heart or skipped heartheats?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Has any family member or realitive died of heart problems or of sudden       unexpected death before age 50?         Has any family member or endiagnosed with enlarged heart.       (dilated cardiomyopathy), hypertrophic cardiomyopathy, long OT syndrome or orber ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or orabnormal heart rhythm?       YES NO         Have you ever head head injury or concussion?       YES NO       Heav you ever been knocked out, become unconscious, or lost your memory?       YES NO         Have you ever head nead asigner?       WES NO       Mater you ever head asigner, burner, or pinched nerv?       YES NO         Have you ever head numbness or tingling in your arms, hands, legs, or feet?       YES NO       Mater you ever head asinger, burner, or pinched ner	s a mir unior hig articipa tudents leight //ision l height //ision l heigh
Have you ever had surgery?       YES NO         3. Have you ever had prior testing for the heart ordered by a physician?       YES NO         Have you ever had hest pain during or after exercise?       YES NO         Have you ever had hest pain during or after exercise?       YES NO         Have you ever had nesting or your heart or skipped heartheats?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Has any family member or relative died of heart problems or of sudden       mexpected death before age 50?         Has any family member or endiagnosed with enlarged heart,       YES NO         Has any family member or endiagnosed with enlarged heart,       YES NO         Has a physician ever denied or restricted your participation in sports for any       YES NO         Has a physician ever denied or restricted your participation in sports for any       YES NO         Have you ever had a heard injury or concussion?       YES NO         Have you ever had numbenss or ingling in your arms, hands, legs, or feet?       YES NO         Have you ever had a starder?       YES NO         Po you have frequent or severe headaches?       YES NO         Have you ever had a starding or after exercisie?       YES NO <th>articipa tudents leight /ision l /ision l //ision l //is</th>	articipa tudents leight /ision l /ision l //ision l //is
3. Have you ever had prior testing for the heart ordered by a physician? YES NO Have you ever had chest pain during or after exercise? YES NO Have you ever had chest pain during or after exercise? YES NO Have you ever had chest pain during or after exercise? YES NO Have you ever had rest of your heart or skipped heartheats? YES NO Have you ever bear loid you have a heart nurmur? YES NO Has any family member or relative died of heart problems or of sudden unexpected death before age 50? YES NO Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or other ion channelopathy (Brugada syndrome,ste), Marfan's syndrome, or wes send one? (Explain below) Have you ever head a seizure? YES NO Have you ever head a stigner, burner, or pinched nerve? YES NO Have you ever head a stigner, burner, or pinched nerve? YES NO Have you ever had a singre, burner, or pinched nerve? YES NO Have you ever had a singre, purperscription or non-prescription (over the counter) medication or pills or using an inhaler (YES NO Have you ever bead nigrady and prescription or non-prescription (over the counter) medication or pills or using an inhaler (YES NO Have you ever bead nigrady and reaverise? YES NO Have you ever bead a syndramic strain, or swelling in muscles, tendons, boyou have asynama? YES NO Have you ever bead nigrady and reaverises or using?	tudents leight /ision l /ision
Have you ever paced out during or after exercise? YES NO Have you ever had chest pain during or after exercise? YES NO Have you ever had chest pain during or after exercise? YES NO Have you ever had chest pressure or high cholesterol? YES NO Have you had high blood pressure or high cholesterol? YES NO Have you ever been told you have a heart nurmur? YES NO Have you ever been told you have a heart nurmur? YES NO Have you ever been told you have a heart nurmur? YES NO Have you have a heart nurmur? YES NO Have you have a heart nurmur? YES NO Have you have a heart nurmur? YES NO reason to harmelopathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart hythm? YES NO Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a head injury or concussion? YES NO Have you ever had a stinger. When was the last concussion? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO Have you ever beard adving or attre? Sting? YES NO Have you ever beard adving or attre? Sting? YES NO Have you ever beard adving or attre? YES NO Have you ever beard adving or attre? Sting? YES NO Have you ever beard dizy during or aftre exercise YES NO Have you ever	leight /ision l hppear yes/E ymph leart-/ he hea bosition leart-/ he hea bosition leart leart-/ he hea bosition leart le
Do you get tired more quickly than your friends do during exercise? YES NO VI Have you ever had racing of your heart or skipped hearbeats? YES NO VI Have you wer been told you have a heart murmu? YES NO VI Has any fimily member or relative died of heart problems or of sudden unexpected death before age 50? YES NO VI Has any fimily member or relative died of heart problems or of sudden unexpected death before age 50? YES NO VI Has any fimily member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or abnormal heart rhythm? YES NO VI Has any fimily member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or abnormal heart rhythm? YES NO VI Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO VI Has a physician ever denied or restricted your participation in sports for any heart problems? When was the last concussion? YES NO VI Have you ever had a seizure? When was the last concussion? YES NO VI Have you ever had a seizure? YES NO VI Have you ever had a subject, burmer, or pinched nerve? YES NO VI Have you ever had a sing paired organs? YES NO VI S. Are you undert a doctor's care? YES NO VI Mave you ever had a stig roblems (itching, rashes, acne, warts fingus, or blisters)? YES NO VI S. Are you undert a doctor's care? YES NO VI Mave you ever bedom and problems (itching, rashes, acne, warts fingus, or blisters)? YES NO VI Have you ever bedom alty problems (itching, rashes, acne, warts fingus, or blisters)? YES NO VI Have you ever bedom aptice that require medical treatment? YES NO Have you ever bed ad aptice with your eyes or vision? YES NO Have you ever bed ad aptice with your eyes or vision? YES NO Have you vere had any problems with your eyes or vision? YES NO Have you uver beend might with your ey	/ /ision l Appear yes/E ymph leart-A he hea tandin leart-L belse Pulses ungs bdom Aarfan Aarfan Ausc Book
Have you ever had racing of your heart or skipped heartbeats?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Have you ever been told you have a heart murmur?       YES NO         Has any family member or relative died of heart problems or of sudden unexpected death before age 50?       YES NO         Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, hong QT syndrome, or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or other viral infection (for example, myocarditis or mononucleosis)       Mathematical States (States States State	/ision l Appear Eyes/E Cymph leart-A he hea toosition leart-A he hea tandin leart-L bulse Pulses Lungs Abdom Benital Skin Aarfan Ausc Sack Bould Elbow/
Have you ever been told you have a heart murmur?       YES NO         Has any family member or relative died of heart problems or of sudden unexpected death before age 50?       YES NO         Has any family member or relative died of heart problems or of sudden unexpected death before age 50?       YES NO         Has any family member or relative died of heart problems or of sudden unexpected death before age 50?       YES NO         Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long OT syndrome or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or ahonrmal heart rhythm?       YES NO         Has any family member or denied or restricted your participation in sports for any heart problems?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a starce?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a starce, burmer, or pinched nerve?       YES NO         S. Are you under a doctor's care?       YES NO         J. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO         M. Have you ever been dizzy during or after exercise       YE	Appear yes/E ymph leart-/ he hea tandin leart-/ he hea tandin leart-/ hea le
Have you ever been told you have a heart murmur?       YES NO         Has any family member or relative died of heart problems or of sudden unexpected death before age 50?       YES NO         Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, hong QT syndrome or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or abnormal heart rhythm?       YES NO         Have you had a severe viral inflection (for example, myocarditis or mononucleosis) within the last month?       YES NO         Has a physician ever denied or restricted your participation in sports for any heart problems?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever been knocked out, become unconscious, or lost your memory?       YES NO         Have you ever had a head sizure?       YES NO         Have you ever had a singer, burner, or pinched nerve?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         S. Are you missing any paried organs?       YES NO         A. ray ou urently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler       YES NO         YES NO       YES NO       YES NO         I. Have you ever been dizzy during or after exercise       YES NO         I. Have you ever been dizzy during or after exercise?       YES NO         I. Have you ever been dizzy during or af	yes/E ymph leart-/ he hea osition leart-/ he hea tandin leart-/ pulses bulse Pulses boulse Marfan MUSC leck Back bhould Elbow/
unexpected death before age 50?       YES NO         Has any family member been diagnosed with enlared heart,       (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or ahormal heart rhythm?       YES NO         Have you had a severe viral infection (for example, myocarditis or mononucleosis)       Within the last month?       YES NO         Have you had a severe viral infection (for example, myocarditis or mononucleosis)       YES NO       H         Have you ver had a head injury or concussion?       YES NO       H         Have you ever had nead injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a secure?       YES NO         How severe was each one? (Explain below)       H         Have you ever had a singer, burner, or pinched nerve?       YES NO         Have you ever had a singer, burner, or pinched nerve?       YES NO         S. Are you mider a doctor's care?       YES NO         A rey ou udre a doctor's care?       YES NO         M. Are you ever been dizzy during or after exercise?       YES NO         M. Have you ever been dizzy during or after exercise?       YES NO         M. Are you udret a doctor's care?       YES NO         M. Are you udret a doctor's care?       YES NO         M. Have you ever beend izzy during or after exercise       YES NO<	yes/E ymph leart-/ he hea osition leart-/ he hea tandin leart-/ pulses bulse Pulses boulse Marfan MUSC leck Back bhould Elbow/
Has any family member been diagnosed with enlarged heart,       A         (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome,       Figure 1         or other ion channelopathy (Brugada syndrome, etc.), Marfan's syndrome,       YES NO         Have you had a severe viral infection (for example, myocarditis or mononucleosis)       YES NO         Have you ever head a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion, or lost your memory?       YES NO         Have you ever had a seizure?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a seizure?       YES NO         Do you have frequent or severe headaches?       YES NO         Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         S. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       M         Have you ever beem dizzy during or after exercise?       YES NO       M         May any user or polition of port set or stinging insects)?       YES NO       M         Are you currently taking any prescription or non-prescription       (over the counter) medication or	yes/E ymph leart-/ he hea osition leart-/ he hea tandin leart-/ pulses bulse Pulses boulse Marfan MUSC leck Back bhould Elbow/
(dilated cardiomyopathy), hyperfrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or abnormal heart rhythm?       YES NO         Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?       YES NO         Has a physician ever denied or restricted your participation in sports for any heart problems?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         How severe was each one? (Explain below)       Have you ever had a siture?       YES NO         Have you ever had numbness or tingling in your arms, hands, legs, or feet?       YES NO       Have you ever had a siture?, or pinched nerve?       YES NO         S. Are you under a doctor's care?       YES NO       So       Are you ever had numbness or tingling in your arms, hands, legs, or feet?       YES NO         B. Do you have frequent or severe headaches?       YES NO       So       Are you currently taking any prescription or non-prescription       GO         Over the counter) medication or pills or using an inhaler       YES NO       Material action or pills or using an inhaler       YES NO         B. Dayou have any allergies (to pollen, medicine, food, or stinging insects)?	yes/E ymph leart-/ he hea osition leart-/ he hea tandin leart-/ pulses bulse Pulses boulse Marfan MUSC leck Back bhould Elbow/
or other ion channelopathy (Brugada syndrome,etc), Marfan's syndrome, or abnormal heart rhythm? YES NO Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO Have you ever head a head injury or concussion? YES NO Have you ever been knocked out, become unconscious, or lost your memory? YES NO Have you ever bead acked out, become unconscious, or lost your memory? YES NO Have you ever had a nead injury or concussion? YES NO Have you ever had a seizure? YES NO Have you ever had asciure? YES NO Have you ever had asciure? YES NO Have you ever had astigner, burner, or pinched nerve? YES NO Have you ever had antinger, burner, or pinched nerve? YES NO Have you ever had antinger, burner, or pinched nerve? YES NO Are you under a doctor's care? YES NO S. Are you under a doctor's care? YES NO 9. Have you ever beed izzy during or after exercise YES NO 9. Have you ever beed izzy during or after exercise YES NO 0. Do you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO 11. Have you ever beed nizzy during or after exercise YES NO 12. Have you ever beed nizzy during or after exercise? YES NO 13. Have you ever gotten unexpectedly short of breath with exercise? YES NO 14. Have you ever gotten unexpectedly short of breath with exercise? YES NO 15. Have you ever gotten unexpectedly short of breath with exercise? YES NO 16. Do you have seasonal allergies that require medical treatment? YES NO 17. Have you ever gotten unexpectedly short of breath with exercise? YES NO 18. Have you ever boken or flactured any bones or dislocated any joints? YES NO 19. Have you ever had a sprain, strain, or swelling after injury? YES NO 19. Have you ever had a sprain, strain, or swelling in muscles, tendons, bones, or joints? YES NO 19. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO 19. Do you have suboken or flactured any	ymph leart-/ he hea oosition leart-/ he hea tandin leart-L oulse Pulses Joulse Pulses Joulse Skin Aarfan AUSC Jeck Back Should
Have you had a severe viral infection (for example, myocarditis or mononucleosis)       Hit         within the last month?       YES NO         Has a physician ever denied or restricted your participation in sports for any       YES NO         heart problems?       YES NO         4. Have you ever had a head injury or concussion?       YES NO         Have you ever head head injury or concussion.       YES NO         Have you ever head acked out, become unconscious, or lost your memory?       YES NO         Have you ever had a sciure?       YES NO         How severe was each one? (Explain below)       Have you ever had acitzme?       YES NO         Have you ever had numbness or tingling in your arms, hands, legs, or feet?       YES NO       Have you ever had acitager, burner, or pinched nerve?       YES NO         5. Are you under a doctor's care?       YES NO       YES NO       S         6. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         9. Have you ever been dizzy during or after exercise       YES NO       M         9. Have you ever been dizzy during or after exercise       YES NO       M         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO       M         11. Have you ever becom eill from exercising in the heat? <t< td=""><td>leart-A he hea oosition leart-A he hea tandin leart-L oulse Pulses Joulse Skin Aarfan Ausc Skin Marfan Ausc Sack Should Elbow/</td></t<>	leart-A he hea oosition leart-A he hea tandin leart-L oulse Pulses Joulse Skin Aarfan Ausc Skin Marfan Ausc Sack Should Elbow/
within the last month?       YES NO       the         Has a physician ever denied or restricted your participation in sports for any       pression         heart problems?       YES NO         4. Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         How severe was each one? (Explain below)       Have you ever had a seizure?       YES NO         Have you ever had a seizure?       YES NO       Person         Do you have frequent or severe headaches?       YES NO       Person         Have you ever had a stinger, burner, or pinched nerve?       YES NO       Person         5. Are you under a doctor's care?       YES NO       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       Messon         9. Have you ever been dizy during or after exercise       YES NO       Messon       Messon         11. Have you ever been dizy during or after exercise?       YES NO       Messon       Messon       Messon	he hea position leart-4 he hea tandin leart-L pulse Pulses Jungs Abdom Genital Skin Aarfan Aarfan MUSCI Neck Back Should
Has a physician ever denied or restricted your participation in sports for any hear problems?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had a head injury or concussion?       YES NO         Have you ever had anothexed out, become unconscious, or lost your memory?       YES NO         Have you ever had a seizure?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         Are you under a doctor's care?       YES NO         C. Are you under a doctor's care?       YES NO         A. Poy ou turrently taking any prescription or non-prescription       (over the country medication or pills or using an inhaler       YES NO         B. Do you have any current skin problems (itching, rashes, acne, warts       fungus, or blisters)?       YES NO         11. Have you ever become ill form exercising in the heat?       YES NO       YES NO         12. Have you ever bacom eill form exercising in the heat?       YES NO       YES NO         13. Have you ever bacom eill form exercising in the heat?       YES NO       YES NO         14. Do you have any problems with your eyes or vision?       YES NO	oosition leart-A he hea tandin leart-L bulse Pulses Jungs Ju
heart problems?       YES NO         4. Have you ever had a head injury or concussion?       YES NO         Have you ever been knocked out, become unconscious, or lost your memory?       YES NO         If yes, how many times?       When was the last concussion?       YES NO         How severe was each one? (Explain below)       Heave you ever had a singer, burner, or pinched nerve?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a singer, burner, or pinched nerve?       YES NO         5. Are you under a doctor's care?       YES NO         6. Are you under a doctor's care?       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       NO         9. Have you ever been dizzy during or after exercise       YES NO       NO         10. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       NO         11. Have you ever become ill from exercising in the heat?       YES NO       NO         12. Have you ave asthma?       YES NO       NO       NO         13. Have you ever bad a sprain, strain, or swelling after injury?       YES NO       YES NO         14. Do	leart-A he hea itandin leart-L bulse Pulses Jung
4. Have you ever had a head mjury or concussion? YES NO If yes, how many times? When was the last concussion? YES NO If yes, how many times? When was the last concussion? YES NO If yes, how many times? When was the last concussion? YES NO Do you have frequent or severe headaches? YES NO Plave you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO A A try you ever had a stinger, burner, or pinched nerve? YES NO A A try you ever had a stinger, burner, or pinched nerve? YES NO A A try you ever had a doctor's care? YES NO A A try you under a doctor's care? YES NO A A try you under a doctor's care? YES NO A A try you ever been dizzy during or after exercise YES NO A B you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO 9. Have you ever been dizzy during or after exercise YES NO 9. Have you ever been dizzy during or after exercise YES NO 9. Have you ever become ill from exercising in the heat? YES NO 10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)? YES NO 11. Have you ever become ill from exercising in the heat? YES NO Do you have asthma? YES NO Do you have stamma? YES NO YES NO Do you have stamma? YES NO Have you ever gotten unexpectedly short of breath with exercise? YES NO Have you ever bashma? YES NO Have you ever had a sprain, strain, or swelling after injury? YES NO Have you whad any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO Hip	he hea tandin leart-L bulse Pulses Jungs Abdom Genital Skin Marfan MuSC Neck Back Should Elbow/
Have you ever been knocked out, become unconscious, or lost your memory?       YES NO         If yes, how many times?       When was the last concussion?         How severe was each one? (Explain below)       YES NO         Have you ever had a seizure?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         Ave you ever had a stinger, burner, or pinched nerve?       YES NO         6. Are you under a doctor's care?       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       M         9. Have you ever been dizzy during or after exercise       YES NO       M         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO       YES NO         11. Have you ever become ill from exercising in the heat?       YES NO       YES NO         12. Have you have asyman?       YES NO       YES NO         13. Have you ever bad a sprain, strain, or swelling intercise?       YES NO         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, re	tandin leart-L pulses Julses Julses Jungs Abdom Genital Skin Marfan MUSC Neck Should Elbow/
How severe was each one? (Explain below)       How severe was each one? (Explain below)         How severe was each one? (Explain below)       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         S. Are you missing any paired organs?       YES NO         6. Are you under a doctor's care?       YES NO         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 (to pollen, medicine, food, or stinging insects)?       YES NO         9. Have you ever been dizzy during or after exercise       YES NO         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       NES NO         11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?       YES NO         14. Do you use any special protective or orrective 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)?       YES NO         15. Have you ever bead asprain, strain, or swelling in muscles, tendons, bones, or joints?       YES N	leart-L bulse Pulses Jungs Abdom Genital Bkin Marfan MUSC Neck Should Elbow/
Have you ever had a seizure?       YES NO         Do you have frequent or severe headaches?       YES NO         Have you ever had a umbness or tingling in your arms, hands, legs, or feet?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         5. Are you missing any paired organs?       YES NO         6. Are you under a doctor's care?       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       M         9. Have you ever been dizzy during or after exercise       YES NO       M         10. Do you have any current skin problems (itching, rashes, acne, warts       M       M         fungus, or blisters)?       YES NO       YES NO       S         11. Have you ever become ill from exercising in the heat?       YES NO       NO         12. Have you had any problems with your eyes or vision?       YES NO       NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO       NO         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 ail?)?       YES NO       H	Pulses ungs Abdom Senital Skin Marfan MUSC Neck Sack Should Elbow/
Do you have frequent or severe headaches?       YES NO         Have you ever had numbness or tingling in your arms, hands, legs, or feet?       YES NO         Have you ever had a stinger, burner, or pinched nerve?       YES NO         5. Are you missing any paired organs?       YES NO         6. Are you under a doctor's care?       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       M         9. Have you ever been dizzy during or after exercise       YES NO       M         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO       N         11. Have you ever become ill from exercising in the heat?       YES NO       N         12. Have you aver agotten unexpectedly short of breath with exercise?       YES NO       N         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO       N         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)?       YES NO       N         15. Have you broken or fractured any bones or dislocated any joints?       YES NO       N	Pulses ungs Abdom Senital Skin Marfan MUSC Neck Sack Should Elbow/
Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO Have you ever had a stinger, burner, or pinched nerve? YES NO 5. Are you unissing any paired organs? YES NO 6. Are you under a doctor's care? YES NO 7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler YES NO 8. Do you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO 9. Have you ever been dizzy during or after exercise YES NO 10. Do you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO 9. Have you ever been dizzy during or after exercise YES NO 10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)? YES NO 12. Have you ever become ill from exercising in the heat? YES NO 13. Have you ever gotten unexpectedly short of breath with exercise? YES NO Do you have asthma? YES NO 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)? YES NO Have you breken or fractured any bones or dislocated any joints? YES NO Have you bad any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO Have you bad any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO Have you vere been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO 16. Do you use they more or less than you do now? YES NO 17. Do you feel stressed out? YES NO 18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO 19. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO 17. Do you feel stressed out? YES NO 18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO 19. When was your first menstrual period? 19. When was your first menstrual period? 19. When	ungs Abdom Genital Skin Marfan MUSC Neck Sack Should Elbow/
Are you ever had a singer, ounler, of pinched nerve:       ILS NO         Are you under a doctor's care?       YES NO         6. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         9. Boy ou have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO         9. Have you ever been dizzy during or after exercise       YES NO         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO         11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you had any problems with your eyes or vision?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         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)?       YES NO         15. Have you broken or fractured any bones or dislocated any joints?       YES NO         14. Have you borken or fractured any bones or dislocated any joints?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         14. Have you broken or fractured	Abdom Genital Skin Marfan MUSC Neck Back Should Elbow/
6. Are you under a doctor's care?       YES NO       G         7. Are you currently taking any prescription or non-prescription       (over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO       M         9. Have you ever been dizzy during or after exercise       YES NO       M         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO       N         11. Have you ever become ill from exercising in the heat?       YES NO       S         12. Have you ever gotten unexpectedly short of breath with exercise?       YES NO       S         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO       H         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)?       YES NO       H         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO       H       H         14. Do you use any special protective or discated any joints?       YES NO       H         15. Have you ever had a sprain, strain, or swelling in muscles, tendons, bones, or joints?       YES NO       H         16. Do you want to weigh more or less than you do now?       YES NO       YES NO <td>Skin Aarfan AUSC Jeck Jeck Jack Should Elbow/</td>	Skin Aarfan AUSC Jeck Jeck Jack Should Elbow/
(over the counter) medication or pills or using an inhaler       YES NO         8. Do you have any allergies (to pollen, medicine, food, or stinging insects)?       YES NO         9. Have you ever been dizzy during or after exercise       YES NO         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO         11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you ever become ill from exercising in the heat?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         Do you have asthma?       YES NO         Do you have seasonal allergies that require medical treatment?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO       Have you broken or fractured any bones or dislocated any joints?       YES NO         If yes, check appropriate box and explain below.	Aarfan AUSC Jeck Back Bhould Elbow/
<ul> <li>8. Do you have any allergies (to pollen, medicine, food, or stinging insects)? YES NO</li> <li>9. Have you ever been dizzy during or after exercise YES NO</li> <li>9. Have you ever been dizzy during or after exercise YES NO</li> <li>10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)? YES NO</li> <li>11. Have you ever become ill from exercising in the heat? YES NO</li> <li>12. Have you ever become ill from exercising in the heat? YES NO</li> <li>13. Have you ever gotten unexpectedly short of breath with exercise? YES NO</li> <li>14. Do you have asthma? YES NO</li> <li>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)?</li> <li>15. Have you ever had a sprain, strain, or swelling after injury? YES NO</li> <li>Have you broken or fractured any bones or dislocated any joints? YES NO</li> <li>Have you broken or fractured any bones or dislocated any joints? YES NO</li> <li>Have you lad any other problems with pain or swelling in muscles, tendons, bones, or joints?</li> <li>If yes, check appropriate box and explain below.</li> <li>Head ElbowHipNeckForearmThighBackWristKnee</li> <li>ChestHandShin/CalfShoulderFingerAnkleUpper ArmFoot</li> <li>16. Do you use to special or cless than you do now? YES NO</li> <li>Do you lose weight regularly to meet weight requirements for your sport? YES NO</li> <li>18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO</li> <li>19. When was your first menstrual period?</li></ul>	AUSC Jeck Back Bhould Elbow/
9. Have you ever been dizzy during or after exercise       YES NO         10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO         11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you had any problems with your eyes or vision?       YES NO         13. Have you ever become ill from exercising in the heat?       YES NO         14. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         15. Have you easonal allergies that require medical treatment?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO       Have you broken or fractured any bones or dislocated any joints?       YES NO         16. Do you usat any other problems with pain or swelling in muscles, tendons, bones, or joints?       YES NO       I         17. boy uo lose weight regularly to meet weight requirements for your sport?       YES NO       YES NO         16. Do you usat to weigh more or less than you do now?       YES NO       YES NO         16. Do you lose weight regularly to meet weight requirements for your sport?       YES NO       I         17. Do you feel stressed out?       YES NO	leck Back Should Elbow/
10. Do you have any current skin problems (itching, rashes, acne, warts fungus, or blisters)?       YES NO         11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you had any problems with your eyes or vision?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         Do you have asthma?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         Have you broken or fractured any bones or dislocated any joints?       YES NO         Mave you had any other problems with pain or swelling in muscles, tendons, bones, or joints?       YES NO         If yes, check appropriate box and explain below.	Back Should Elbow/
11. Have you ever become ill from exercising in the heat?       YES NO         12. Have you had any problems with your eyes or vision?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         Do you have asthma?       YES NO         Do you have asthma?       YES NO         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, too orthotics, retainer on your teeth, hearing aid)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         16. Have you broken or fractured any bones or dislocated any joints?       YES NO         Have you broken or fractured any bones or dislocated any joints?       YES NO         If yes, check appropriate box and explain below.	Should Elbow/
12. Have you had any problems with your eyes or vision?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         Do you have sashma?       YES NO         Do you have seasonal allergies that require medical treatment?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         Have you broken or fractured any bones or dislocated any joints?       YES NO         Have you broken or fractured any bones or dislocated any joints?       YES NO         Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?       YES NO         If yes, check appropriate box and explain below.	Elbow/
13. Have you ever gotten unexpectedly short of breath with exercise?       YES NO         Do you have asthma?       YES NO         Do you have seasonal allergies that require medical treatment?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         Have you boken or fractured any bones or dislocated any joints?       YES NO         Head	
Do you have seasonal allergies that require medical treatment?       YES NO         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)?       YES NO         15. Have you ever had a sprain, strain, or swelling after injury?       YES NO         Have you broken or fractured any bones or dislocated any joints?       YES NO         Have you bad any other problems with pain or swelling in muscles, tendons, bones, or joints?       YES NO         If yes, check appropriate box and explain below.       YES NO	
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? YES NO Have you broken or fractured any bones or dislocated any joints? YES NO Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? 16. Lead	Vrist/⊢
usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? YES NO Have you ever had a sprain, strain, or swelling after injury? YES NO Have you broken or fractured any bones or dislocated any joints? YES NO Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO If yes, check appropriate box and explain below. 	lip/Thi
foot orthotics, retainer on your teeth, hearing aid)? YES NO 15. Have you ever had a sprain, strain, or swelling after injury? YES NO Have you boken or fractured any bones or dislocated any joints? YES NO Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO If yes, check appropriate box and explain below. 	nee
Have you broken or fractured any bones or dislocated any joints? YES NO Have you broken or fractured any bones or dislocated any joints? YES NO Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO If yes, check appropriate box and explain below. 	.eg/An
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO If yes, check appropriate box and explain below. 	oot
bones, or joints? YES NO USEN IN part of ording in more strong in	LEAR
If yes, check appropriate box and explain below. HeadElbowHipNeckForearmThighBack WristKnee ChestHandShin/CalfShoulderFingerAnkle Upper ArmFoot 16. Do you want to weigh more or less than you do now? YES NO Do you lose weight regularly to meet weight requirements for your sport? YES NO 17. Do you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO I choose not to provide written information on Question 19 or Questions 20 but will discuss with a medical professional. Females Only 19. When was your first menstrual period? When was your most recent menstrual period? other period?	Clea
Chest HandShin/CalfShoulderFingerAnkleUpper ArmFoot         16. Do you want to weigh more or less than you do now? YES NO         Do you lose weight regularly to meet weight requirements for your sport? YES NO         17. Do you eel stressed out? YES NO         18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO         16. Do you first menstrual period?         17. Do you first menstrual period?	
<ul> <li>16. Do you want to weigh more or less than you do now? YES NO Do you lose weight regularly to meet weight requirements for your sport? YES NO T7. Do you feel stressed out?</li> <li>17. Do you feel stressed out? YES NO YES NO</li></ul>	] Clea
Do you lose weight regularly to meet weight requirements for your sport? YES NO 17. Do you feel stressed out? YES NO 18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO <u>I choose not to provide written information on Question 19 or Questions 20</u> <u>but will discuss with a medical professional.</u> Females Only 19. When was your first menstrual period?	
17. Do you feel stressed out?       YES NO         18. Have you ever been diagnosed w/ or treated for sickle cell trait or Sickle cell disease? YES NO       The provide written information on Question 19 or Questions 20 <u>but will discuss with a medical professional.</u> The provide written information on Question 19 or Questions 20         Females Only       Nu         19. When was your first menstrual period?       Nu         When was your most recent menstrual period?       ott	Not
I choose not to provide written information on Question 19 or Questions 20       Ph         but will discuss with a medical professional.       Ph         Females Only       a F         19. When was your first menstrual period?       Nu         When was your most recent menstrual period?       ott	
Inclusion into the provide written information on Question 19 of Question 20       Ph         but will discuss with a medical professional.       a F         Females Only       Nu         19. When was your first menstrual period?       Nu         When was your most recent menstrual period?       ott	ne follo
Females Only       a H         19. When was your first menstrual period?       Nu         When was your most recent menstrual period?       oth	hysicia
19. When was your first menstrual period?       Nu         When was your most recent menstrual period?       oth	Regist
	urse E
How much time do you usually have from the start of one	her he
period to the start of another?	hysi
How many periods have you had in the last year? A	ddre
What was the longest time between periods in the last year? Pl	hone
Males Only 20. Do you have two testicles?	hysi
	ate:
*Explain "Yes" answers here: A "yes" on questions 1, 2, 3, 4, 5, or 6 requires a further medical	u.c.
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,gamesormatches)	$\Box A$
	under
THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.	Arres
It is understood that even though protective equipment is worn by the athlete, whenever needed, the	stude
possibility of an accident still remains. Neither the University Interscholastic League nor the school	about
assumes any responsibility in case an accident occurs. If, in the judgment of any representative of the school, the above student should need immediate	sched
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 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.	
	Prin

Student Signature: \_\_\_\_\_

ID#\_\_\_\_\_

ARTICIPATION PHYSICAL EVALUATION- PHYSICAL EXAMINATION inimum requirement, this Physical Examination Form must be completed prior to igh athletic participation and again prior to first and third years of high school athletic ation. It must be completed if there are yes answers to specific questions on the s Medical History Form. Hays CISD requires annual completion of this form.

Height	Weight	Body Fat_	Pulse	BP	/		
(,/)-brachial blood pressure while sitting							
Vision R 2	0/L2	0/Correc	ted: Y N	Pupils: Equa	I OR	Unequal	

MEDICAL	NORMAL	ABNORMAL FINIDINGS	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			
pulse			
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			

ANCE {Please check one}

ared (No restrictions)

ared after completing evaluation/rehabilitation for:

Not	cleared	for:
	Re	ason:

owing information must be filled in and signed by either a Physician, a an Assistant licensed by a State Board of Physician Assistant Examiners, stered Nurse recognized as an Advanced Practice Nurse by the Board of Examiners, or a Doctor of Chiropractic. Examination forms signed by any ealth care practitioner will not be accepted.

cian Name (print/type):\_\_\_\_\_ ess: e Number: cian Signature:

An electrocardiogram (ECG) is not required. I have read and rstand the information about cardiac screening on the UIL Sudden Cardiac st Awareness Form. By checking this box, I choose to obtain an ECG for my ent for additional cardiac screening. I have read and understand the information t cardiac screening. I understand it is the responsibility of my family to dule and pay for such ECG.

## FOR SCHOOL USE ONLY: This medical history form was reviewed by:

ted Name: \_\_\_\_\_

Signature:

Date:

Parent Signature:

## Athlete Contact Information

Student Last Name	Student First Name		Middle Init	ial Stud	lent ID #
				I	
Student Date of Birth	School Student Atten	ding		Grade in 20	025-2026
	I				
Home Telephone Number	Cell Phon	e Number			
		I	I		
Street Address (No P.O. Boxes)		City		Zip Code	
	I	1	I		
Parent/Guardian's Name	Employer	Bus. Phone	e Number	Cell Phone I	Number
	I	/			
Parent/Guardian's Name	Employer	Bus. Phone	Number	Cell Phone Nu	umber
	I		I		
Emergency Contact Name	Home/Cell Pl	none Number	Alter	nate Contact	Number
(Non-Parent must be 18 years	or older)				

Everyone needs a New Physical Dated after April 1st

## **Online Form Instructions**

Parent/Guardian: Before your child is able to participate in athletics you will need to complete the following: Navigate to <u>*Hayscisd.rankone.com/pro/login*</u>

- Create a parent account
- To complete each page you will need your athlete's first name, last name, student ID#
  - UIL Signature Page Code of Conduct
  - UIL Forms (Available in Spanish) you will need to fill in every blank and check each box affirming that you have read and agree with the presented material:
    - 1. Acknowledgement of Rules
    - 2. Concussion Acknowledgement Form
    - 3. Sudden Cardiac Arrest Awareness Form
    - 4. UIL Safety Training
    - 5. Parent/Student Steroid Agreement Form

## Follow the QR CODE to complete RANKONE Forms ONLINE.



- Student and Parent/Guardian will need to provide signature at the end of the page along with a working email address.

Once you have completed the online forms, medical history, physical exam, athlete contact information portion of this form and turned it in to the Athletic Trainers (High School)/Coach (Middle School), then your child will be eligible to participate in fine arts/athletics (this includes practices/performances during, before, after school, and offseason).