Texas Association of Private and Parochial Schools
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: _____

Texas Association of Private and Parochial Schools
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 or experienced any condition which would make it hazardous to participate in an athletic event.

STUDENT'S NAME: _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____ PARENT CELL: _____

SCHOOL: _____ GRADE LEVEL: _____

PERSONAL PHYSICIAN: _____

PHONE: _____

In case of emergency, contact:

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. Written clearance from a physician, physician 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 check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Have you ever passed out during or after exercise?	☐	☐
5.	Have you ever had chest pain during or after exercise?	☐	☐
6.	Do you get tired more quickly than your friends do during exercise?	☐	☐
7.	Have you ever experienced racing of your heart or skipped heartbeats?	☐	☐
8.	Have you had high blood pressure	☐	☐
9.	Have you ever had high cholesterol?	☐	☐
10.	Have you ever been told you have a heart murmur?	☐	☐
11.	Has any family member or relative died of heart problems before age 50?	☐	☐
12.	Has any family member or relative died of sudden unexpected death before age 50?	☐	☐
13.	Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	☐	☐
14.	Has any family member been diagnosed with Hypertrophic Cardiomyopathy?	☐	☐
15.	Has any family member been diagnosed with Long QT Syndrome?	☐	☐
16.	Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	☐	☐
17.	Has any family member been diagnosed with Marfan's Syndrome?	☐	☐
18.	Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?	☐	☐
19.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐

Sudden Cardiac Arrest occurs in persons of all ages. The answers to questions # 4-19 above will assist in determining whether additional testing may be required for your son or daughter. If you have answered yes to any of these questions, please review with your health care professional whether additional testing may be necessary including but not limited to EKG and /or ECG.

20.	Have you ever had a head injury or concussion?	☐	☐
21.	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
22.	Have you ever had a seizure?	☐	☐
23.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐

24. Have you ever had a stinger, burner, or pinched nerve? ☐ ☐
25. Are you missing any paired organs? ☐ ☐
26. Are you presently under a doctor's care? ☐ ☐
27. Are you currently taking any prescription or non-prescription medication or inhalers? ☐ ☐
28. Do you have any allergies? ☐ ☐
29. Have you ever been dizzy before or during exercise? ☐ ☐
30. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)? ☐ ☐
31. Have you ever become ill from exercising or working in the heat? ☐ ☐
32. Have you had any problems with your eyes or vision? ☐ ☐
33. Have you ever gotten unexpectedly short of breath with exercise? ☐ ☐
34. Do you have asthma? ☐ ☐
35. Do you have seasonal allergies that require medical treatment? ☐ ☐
36. Do you use any special protective or corrective equipment? ☐ ☐
37. Have you ever had a sprain, strain, or swelling after injury? ☐ ☐
38. Have you broken or fractured any bones? ☐ ☐
39. Have you ever dislocated any joints? ☐ ☐
40. 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	☐	Shoulder	☐	Wrist	☐	Thigh	☐	Foot	☐
Neck	☐	Upper Arm	☐	Hand	☐	Knee	☐		
Back	☐	Elbow	☐	Finger	☐	Shin/Calf	☐		
Chest	☐	Forearm	☐	Hip	☐	Ankle	☐		

41. Do you want to weigh more or less than you do now? ☐ ☐
42. Do you lose weight regularly to meet weight requirements for your Extra-curricular activities ☐ ☐
43. Do you feel stressed out? ☐ ☐
44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? ☐ ☐

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 periods in the last year? ____days

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither **Texas Association of Private and Parochial Schools** nor the school assumes any responsibility in case an accident occurs. The possibility of transfer of disease exists whenever blood transfer occurs. While the risk is minimal with high school activities, by signature below we recognize the possibility exists relating to blood borne pathogens and the transfer of disease such as Hepatitis or HIV.

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, 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 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/GUARDIAN SIGNATURE: _____ DATE: _____

For School Use Only:

This Medical History Form reviewed by: NAME: _____ **DATE:** _____