

Sports: _____

PFLUGERVILLE ISD - ATHLETIC EMERGENCY STUDENT INFORMATION CARD

Last Name: _____ First Name: _____ School ID# _____

Date of Birth: ____/____/____ Age: ____ Student's cell _____ Grade: _____

Address: _____ City: _____ Zip: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Mother's cell _____ Father's cell _____

Person to reach if parents cannot be notified: _____ Phone: _____

SPECIAL CONSIDERATIONS THAT SHOULD BE KNOWN BY ATHLETIC TRAINING STAFF MEMBERS

Allergies: _____ Medications taken Regularly: _____

Corrective Lenses _____ Contacts _____ Asthma _____ Insurance Co. Name _____

ID# _____ Phone: _____

Employer Name: _____ Group # _____

PFLUGERVILLE ISD - MEDICATION PERMIT FORM

This medication permit form is required for compliance of the Texas Education Agency School Health Act and P.I.S.D. Board Policy

PARENTAL PERMISSION FOR ADMINISTRATION OF "OVER-THE-COUNTER-MEDICATION"

_____ has my permission to receive the Over-the-Counter medications while participating in UIL sanctioned athletics during the upcoming school year. I, the parent/guardian have reviewed the OTC medications listed below on this form. The dispensing of these medications shall be limited to and exclusive only to the PISD employed and licensed Athletic Trainers.

I, the parent/guardian, understand that the medications listed below are industrial strength-generic forms of those.

___ YES ___ NO Any and all name brand Advil (ibuprofen) and Tylenol (acetaminophen) or generic forms of those.

___ YES ___ NO Any and all name brand Mylanta (antacid) or generic form of these.

___ YES ___ NO FOSSFREE OR ELECTROLYTE (calcium, vitamins & iron) for relief and prevention of muscle cramps. Administered in cases of fluid loss and extreme heat.

I, parent/guardian have checked or indicated which medications SHALL NOT BE ADMINISTERED to my son/daughter.

• EXCEPTIONS: _____

PARENT OR GUARDIAN'S PERMIT

I hereby give consent for the above student to compete in University Interscholastic approved sports and travel with coaches or other representatives of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the UIL nor the high school assumes any responsibility in case such accident occurs.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If in the judgment of any school official, 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, athletic 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.

Parent/Guardian Signature: _____ Date: _____

**Parent and Student Notification/Agreement Form
Illegal Steroid Use**

Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.

Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.

Texas state law requires that only a medical doctor may prescribe a steroid for a person.

Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

HEALTH CONSEQUENCES ASSOCIATED WITH ANABOLIC STEROID ABUSE

(source: National Institute on Drug Abuse)

- *In boys and men*, reduced sperm production, shrinking of the testicles, impotence, difficulty or pain in urinating, baldness, and irreversible breast enlargement (gynecomastia).
- *In girls and women*, development of more masculine characteristics, such as decreased breast size, deepening of the voice, excessive growth of body hair, and loss of scalp hair.
- *In adolescents of both sexes*, premature termination of the adolescent growth spurt, so that for the rest of their lives, abusers remain shorter than they would have been without the drugs.
- *In males and females of all ages*, potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension, each of which can promote heart attack and stroke; and acne. Although not all scientists agree, some interpret available evidence to show that anabolic steroid abuse-particularly in high doses-promotes aggression that can manifest itself as fighting, physical and sexual abuse, armed robbery, and property crimes such as burglary and vandalism. Upon stopping anabolic steroids, some abusers may experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, headache, muscle and joint pain, and the desire to take more anabolic steroids.
- *In injectors*, infections resulting from the use of shared needles or non-sterile equipment, including HIV/AIDS, hepatitis B and C, and infective endocarditis, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

Student Certification

I have read the above information and agree that a prerequisite of my participation in UIL athletic activities is that I refrain from illegal steroid use. As a prerequisite to participation, I agree that I will not use illegal steroids. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Signature

Date

Parent/Guardian Certification

I have read the above information and acknowledge that a prerequisite of my student's participation in UIL athletic activities is that they refrain from illegal steroid use. I understand that failure to provide accurate and truthful information could subject the participant in question to penalties as determined by UIL.

Parent/Guardian Signature

Date

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-11-06

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: _____ 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 on an additional sheet. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 5, 7, 11, or 17 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		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	12. 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)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	13. 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.	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy 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, hypertrophic cardiomyopathy, long QT syndrome, 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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? _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		
9. Have you ever gotten unexpectedly short of breath with exercise? Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? _____ Do you have seasonal allergies that require medical treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	17. Are you under a doctor's care? Females Only	<input type="checkbox"/>	<input type="checkbox"/>
			18. 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 five 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.		

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 high 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.

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

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

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)

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			

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.