

This MEDICAL HISTORY FORM must be completed annually by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
Address _____ Phone _____
Grade _____ School _____
Personal Physician _____ Phone _____
In case of emergency, contact:
Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Ycs" answers in the box below**. Circle questions you don't know the answers to.

1. Have you had a medical illness or injury since your last check up or physical? Yes No
2. Have you been hospitalized overnight in the past year? Yes No
3. Have you ever had prior testing for the heart ordered by a physician? Yes No
4. Have you ever had a head injury or concussion? 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 (for example, 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 (for example, 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 activity 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
16. Do you want to weigh more or less than you do now? Yes No
17. Do you feel stressed out? Yes No
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? Yes No
19. When was your first menstrual period? When was your most recent menstrual period?
20. Do you have two testicles?
21. Do you have any testicular swelling or masses?
If yes, check appropriate box and explain below:
Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Finger Foot Hip Thigh Knee Shin/Calf Ankle

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.
If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.
If, between this date and the beginning of 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.

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: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:
This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____