7173 FM 1628
San Antonio, TX 78263
(210) 581-1173

East Central ISD Athletic Training

May 4, 2020

To Parents of East Central ISD Athletes:

We are pleased that your child has decided to participate in athletics at East Central. Athletics provides a great opportunity for extra-curricular activity and is an excellent opportunity for character development. This packet contains all of the information required by the University Interscholastic League and ECISD in order for your child to participate in athletics. Due to the novel coronavirus, UIL and ECISD have amended some of the requirements for participation in athletics, marching band, cheer, & dance for the 2020-2021 school year.

All students in grades 7-12 will be required to complete the Medical History portion of the UIL Pre-Participation physical form. In addition, ALL incoming 7th grade athletes, incoming 9th grade band members, and ANY student that did not participate in athletics, marching band, cheer, or dance during the 2019-2020 school will also be required to get a physical from a physician, physician assistant, advanced practice nurse, or doctor of chiropractic. Any student, regardless of grade, who answers "YES" to any question on the medical history may be required to seek further medical examination which may include a physical and/or other testing.

Please go to the following website: **eastcentralisd.rankonesport.com**; and complete the electronic forms listed under "Emergency & Travel Forms" and "UIL/Athlete Participation Forms". ALL boxes must have something in them. If you do not have that information then place "NA" in those boxes. The form will not submit if boxes are left blank. Once you click the "Submit" button the forms are uploaded to our database; no need to print and send them to school. If you misplace the attached physical form you can download and print a copy from the same website under the "Download & Print" tab. This is the only form that must be brought in to the school as the physician must complete this also. All of these forms must be on file before your child can participate in **ANY PRACTICE, BEFORE, DURING, OR AFTER SCHOOL (BOTH IN-SEASON & OUT-OF-SEASON) OR PERFORMANCE/GAME/MATCH**.

Once the medical history, and physical if needed, are completed please scan or take a picture with your phone/tablet and email to: **athletictraining@ecisd.net**. If you are unable to return the forms electronically, there will be a drop off box outside of the district athletic office (located across from the ECISD Police Department near the high school) starting on June 1.

If you need a paper copy of the Emergency & UIL forms these are available at the meal distribution sites and from the district athletic office starting on June 1.

If your child is covered under a medical insurance policy, please provide all information should your child require emergency medical attention. Personal insurance is to be applied initially concerning ALL medical bills. The school's athletic insurance will be applied after the athlete has applied his or her personal insurance or has no personal insurance. The school's athletic insurance only covers accidents/injuries sustained in the **supervised athletic program**. Such activities as "open gym' are **not** covered. Any remaining balance after all insurances have paid will be the responsibility of the parent/guardian.

If you have any questions please call (210) 581-1181.

"The greatest accomplishment is not in never falling, but in rising again after you fall."
Vince Lombardi

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

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

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out 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, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), 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 activities for any heart problems?	☐	☐
4.	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 your 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?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
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 (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
15.	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:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. 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? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

****EXPLAIN "YES" ANSWERS ON THE CORRESPONDING LINES ON THE FOLLOWING PAGES****

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 ED CHAMPAGNE; MEd, LAT, ATC NICOLE CURITS; MAT, LAT, ATC Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

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

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

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 participation and again prior to first and third years of high school 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			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
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 performance/ games/matches.

Medical History Answer Sheet

Explain "YES" answers to any question on the medical history on the appropriate line.

1. _____

2. _____

3. _____

_____

_____

_____

4. When did you suffer your concussions and how severe were they?
   #1 Date: _____ Severity: _____ #2 Date: _____ Severity: _____

   #3 Date: _____ Severity: _____ #4 Date: _____ Severity: _____

5. _____

6. I am under the care of Dr. _____ for _____.

7. I am currently taking the following medications: _____

_____

8. I am allergic to: _____

   Known reaction(s): _____

   Do you carry/use an epi-pen for these allergies? YES ☐ NO ☐

9. _____

10. My current skin problem is: _____

11. _____

12. I wear glasses ☐ contacts ☐

13. If you have asthma, what medications do you use: _____
    I have seasonal allergies _____ (check)

14. _____

15. **Include side of body and year the below injures occurred**
    I have sprained my _____
    I have strained my _____
    I have broken/fractured my _____
    I have dislocated my _____
    I have had pain or swelling in my _____

16. I want to weigh more / less than I do now. I lose weight for _____ (sport).

17. I feel stressed out because _____

18. _____