

School Year: 2007-2008

Grade: _____

<p>CLEAR CREEK INDEPENDENT SCHOOL DISTRICT UNIVERSITY INTERSCHOLASTIC LEAGUE PHYSICIAN'S & PARENT CERTIFICATE FOR PARTICIPATION</p>
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Attention: This form **MUST** be filled out **COMPLETELY**, signed by either a Physician, a Physician Assistant, licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic, signed by both the student and parent/guardian, and on file with the athletic trainer **BEFORE** the student will be allowed to participate in any class period practice, tryout, practice session, scrimmage, or game.

Name: _____ D.O.B. _____ Sex: M / F

Parent/Guardian Name: _____ Phone # () _____

Address: _____
(Street Address, City, State, Zip Code)

Mom: Home # () _____ Work # () _____ Other # () _____

Dad: Home # () _____ Work # () _____ Other # () _____

Emergency Contact: _____ Phone: _____

School: _____

Sport / Activity: _____

School Year: 2007-2008

Grade: _____

<p>CLEAR CREEK INDEPENDENT SCHOOL DISTRICT EMERGENCY CARD / CONSENT FOR TREATMENT</p>
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Name: _____ D.O.B. _____ Sex: M / F

Parent/Guardian Name: _____ Phone # () _____

Address: _____
(Street Address, City, State, Zip Code)

Mom: Home # () _____ Work # () _____ Other # () _____

Dad: Home # () _____ Work # () _____ Other # () _____

In case of emergency and parent / guardian cannot be reached, please contact:

Name: _____ Phone # () _____

In the event that the parents / guardian of the above named student cannot be contacted, I hereby accept the emergency services of the team physician and athletic trainer and hereby authorize the athletic trainer, coach, and other school officials to sign such papers as may be required to obtain immediate medical attention necessary for the welfare and safety of such student. 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 the said student.

_____ Date

_____ Student Signature

_____ Parent Signature

REQUIRED INSURANCE INFORMATION

The undersigned are the parents / guardians of _____, a student in the Clear Creek Independent School District who intends to participate in interscholastic competition during the 2007-2008 school year. We have been advised that the Clear Creek Independent School District provides the opportunity to purchase an insurance program for protection of such students who participate in interscholastic competition against bodily injury sustained by such students while training for or engaging in such competition. Based on the above acknowledgement, we declare the following (THIS IS REQUIRED, please check all that apply):

- ___ A. We have **NO** personal insurance provider coverage and **DO NOT** desire to purchase the insurance coverage offered through the school district.
- ___ B. We **DO** choose to purchase the insurance coverage offered through the school district.
Plan purchased: _____
- ___ C. We choose to have our child covered by a personal insurance provider **ONLY**.
Please provide the following information:
Insurance Company: _____ Phone # () _____
Name of Insured: _____ Group Policy # _____

We further acknowledge that, pursuant to the Texas Tort Claims Act, the Clear Creek Independent School District cannot be held liable for any injuries sustained in training or interscholastic competition, and we therefore agree that no legal action may be brought against the District arising from any such injuries.

Date	Student Signature	Parent Signature
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MUST BE SIGNED BY EACH FOOTBALL PARTICIPANT AND PARENT

WARNING: No helmet can prevent all head or neck injuries a player might receive while participating in football. Do not use the helmet to butt, ram, or spear an opposing player. This is a violation of the football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent.

Date	Student Signature	Parent Signature
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REQUIRED INSURANCE INFORMATION (please check & fill out ALL that apply):

- ___ A. **NO** insurance provider coverage at all.
- ___ B. CCISD School Insurance provider coverage: Plan purchased: _____
- ___ C. Personal insurance provider coverage:
Insurance Company: _____ Phone # () _____
Name of Insured: _____ Group Policy # _____

MEDICAL HISTORY (respond to ALL)

Allergies? Yes / No	Allergies to medications? Yes / No	Asthma? Yes / No
Contacts/Glasses? Yes / No	Diabetes? Yes / No	Epilepsy? Yes / No
Heart Trouble? Yes / No		

Please explain all "Yes" answers and list all drug allergies and/or medications taken regularly: _____

I hereby certify that all of the above information is true to the best of my knowledge.

Date	Student Signature	Parent Signature
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PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 11-3-06

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 in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 5, 7, 11, or 16 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? <input type="checkbox"/> <input type="checkbox"/> Do you have frequent or severe headaches? <input type="checkbox"/> <input type="checkbox"/> Have you ever had numbness or tingling in your arms, hands, legs, or feet? <input type="checkbox"/> <input type="checkbox"/> Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you feel stressed out? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you under a doctor's care? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? <input type="checkbox"/> <input type="checkbox"/> Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Females Only 17. 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. **EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): _____ _____ _____		

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.