☐ **ATHLETIC** ☐ **FINE ARTS** **Campus:**_____ **Grade 2020-2021:**_____

CLEAR CREEK INDEPENDENT SCHOOL DISTRICT
UNIVERSITY INTERSCHOLASTIC LEAGUE
PHYSICIAN'S & PARENT CERTIFICATE FOR PARTICIPATION

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, game, performance or camp for band, color guard or dance team. **THIS PHYSICAL EXPIRES AT THE END OF THE 2020-2021 SCHOOL YEAR.**

CCISD REQUIRES THE DATE OF THE PHYSICAL EXAMINATION TO BE ON OR AFTER APRIL 1, 2020 FOR THE 2020-2021 SCHOOL YEAR.

EMERGENCY CARD / CONSENT FOR TREATMENT

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

Complete Address:_____

Parent Name: _____Primary #( )_____ Other #( )_____

Parent Name: _____Primary #( )_____ Other #( )_____

Parent Email Address: _____ _____

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

Name:_____ Phone #( )_____

REQUIRED INSURANCE INFORMATION (please check & fill out ALL that apply):

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 2020-2021 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. We have further been advised that CCISD does not provide any additional insurance coverage. Based on the above acknowledgement, we declare the following (**THIS IS REQUIRED**, please check all that apply):

____ A. We **HAVE** or we **WILL** purchase the insurance coverage offered through the school district, after August 1, 2020 to be effective for the 2020-2021 school year. Plan purchased:_____

____ B. We choose to have our child covered by a personal insurance provider **ONLY**.
Please provide the following information:
Insurance Company: _____ Phone #( )_____
Name of Insured:_____ Policy ID #_____

_____C. We **REFUSE/DO NOT** have or plan on purchasing Insurance. _____ *must be initialed by parent(s)*

MEDICAL HISTORY (circle one answer for each question)

Allergies? Yes / No | Allergies to medications? Yes / No | Asthma? Yes / No

Heart Trouble? Yes / No | Contacts/Glasses? Yes / No | Epilepsy? Yes / No

History of Concussion? Yes / No | Sickle Cell Trait or Disease? Yes / No | Diabetes? Yes / No

Please explain all "Yes" answers: _____

Please list all drug allergies: _____

Please list any medications taken regularly: _____

In the event that the parents / guardian of the above named student cannot be contacted, I hereby accept the emergency services of the team doctor 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. I hereby certify that all the information provided is true to the best of my knowledge.

_____ _____ _____

Date | Student Signature | Parent / Guardian Signature

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

School:_____ Grade:_____ Student ID#:_____

Activities participating in for 2020-2021:

	Basketball		Baseball		Cheer
	Cross Country		Football		Golf
	Power Lifting		Softball		Soccer
	Student Athletic Trainer		Swim		Tennis
	Track		Volleyball		Water Polo
	Wrestling				
	Band		Color Guard		Dance

IMPORTANT LEGAL NOTICE:

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.

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.

Pursuant to House Bill 82, Sec. 33.205 (a) A coach, trainer, or sponsor for an extracurricular athletic activity shall at each athletic practice or competition ensure that: (2) any prescribed asthma medication for a student participating in the activity is readily available to the student.

Your signature below gives authorization that is necessary for the Clear Creek Independent School District, and/or staff members, its athletic trainers, coaches & sponsors, associated doctors, school administration personnel and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Must be signed by all

_____ _____ _____

Date Student Signature Parent / Guardian Signature

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 IN THE BOX BELOW (attach another sheet if necessary):

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 _____

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.