2017- 2018
~~2016-2017~~ HALLSVILLE ISD UIL ATHLETIC PARTICIPATION FORM (BLUE OR BLACK INK ONLY PRINT LEGIBLY)

HALLSVILLE ISD ATHLETICS WILL ONLY ACCEPT PHYSICALS DATED AFTER APRIL 1ST OF THE CALENDAR YEAR FALL SPORTS BEGIN.

School id. #_____ Gender: M__ F__ Grade: 7__ 8__ 9__ 10__ 11__ 12__

Student's name:_____ Address_____

City/Zip_____ Student cell phone_____

SS#_____ DOB_____ AGE:____

List current medications_____

Drug allergies_____ Allergies_____

Current medical conditions:_____ Asthma Y or N

Diabetes Y or N Other_____

Incoming 7,9,11 grade athletes must have a current physical an annual physical may be needed if any major changes in medical history occur!!

Male parent_____	Female Parent_____
Home phone_____	Home phone_____
Cell phone_____	Cell phone_____
Work phone_____	Work phone_____
Email_____	Email_____

Emergency contact in case parent/guardian CANNOT be reached

Name_____ Home phone_____

Cell Phone_____ Work phone_____

Relationship_____ Family Physician_____

Physician office phone_____

Insurance Company name:_____ Address_____

Policy/Group no:_____

__check if covered by Medicaid or CHIP __ check if not covered under any health insurance plan

Hallsville ISD drug testing:

I understand that my child may be asked to provide a urine sample for drug testing.

I understand that my child cannot be compelled to produce a urine sample, the producing of a sample if requested is a condition of my childs continued participation in extracurricular activities.

I understand that if a test of my childs specimen reveals the presence of an unexplained drug the district may take action against my child up to and including suspension of participation in extracurricular activities

A copy of the HISD drug testing policy can be found in the student code of conduct or online at www.hisd.com.

MEDICATION PERMISSION: Athletic trainers licensed by the state of Texas(LAT) and employed by Hallsville ISD are herby given my permission and consent to administer non prescription over the counter(OTC) medications to my child. OTC medications include but are not limited to Tylenol, Advil, Aleve, Imodium AD, Benadryl, Sudafed, Emetrol, Pepto Bismol, Robitussin, cough drops, electrolytes or generics.

X PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

PHYSICAL EXAMINATION:

STUDENT'S NAME_____ **SEX** _____ **AGE** _____ **DATE OF BIRTH** ____/____/_____

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. Must be completed prior to any practice, game or scrimmage.**

This column is to be completed by Physician, Physician Assistant, Nurse Practitioner or Doctor of Chiropractic:

Height_____ **Weight** _____ **Pulse** _____ **BP**_____/_____

Vision: **R 20/**_____ **L 20/**_____

Pupils: Equal _____ **Unequal** _____ **Corrected: Y N**

Medical	Normal	Abnormal
Appearance		
Eyes / Ears / Nose / Throat		
Lymph Nodes		
Heart Auscultation (Supine)		
Heart Auscultation (Standing)		
Heart Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (Males Only)		
Skin		
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)		
Musculoskeletal	**Normal**	**Abnormal**
Neck		
Back		
Shoulder / Arm		
Elbow / Forearm		
Wrist / Hand		
Hip / Thigh		
Knee		
Leg / Ankle		
Foot		

THE ABOVE STUDENT ATHLETE IS:

- ☐ CLEARED WITH NO RESTRICTIONS
- ☐ CLEARED AFTER EVAULATION FOR THE FOLLOWING

Findings: _____

- ☐ NOT CLEARED FOR PARTICIPATION

Reason: _____

Other 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: ____/____/____

Address: _____

_____

Phone Number: _____

Signature: _____

HEALTHCARE PROVIDER'S STAMP

UIL CONCUSSION ACKOWLEDGEMENT FORM

Name of student athlete_____

A concussion is a complex pathophysiological process affecting the brain caused by impact to the head or body which may include temporary or prolonged altered brain function resulting in physical cognitive or emotional symptoms or altered sleep patterns and involve loss of consciousness.

Signs and symptoms of a concussion may include but not limited to headache, dazed or stunned appearance, ringing in the ears, fatigue, slurred speech, nausea, vomiting, dizziness, loss of balance, blurred vision, light or noise sensitivity, fell foggy or groggy, memory loss or confusion.

Each district shall appoint and approve a concussion oversight team made up of at least one physician and one athletic trainer employed by the district if possible. Other members may include advanced practice nurse neuropsychologist, or a physician assistant. The COT is charged with developing a return to play program based on peer reviewed scientific evidence.

Treatment- the student athlete shall be removed from practice or competition immediately if suspected to have a concussion. The athlete suspected of having a concussion shall be seen by a physician before returning to athletic participation. The treatment is cognitive rest. Students should limit external stimulation such as television, video games, text messaging, computer use, and bright lights. When all symptoms and signs of a concussion have cleared and the student has received written clearance from a physician, the student may begin the return to play protocol as determined by the concussion oversight team.

Texas Education Code section 38.157 states

Return to play: A student removed from athletic participation due to a concussion may not return to practice or competition until:

The student has been evaluated using established medical protocols based on peer reviewed scientific evidence by a treating physician chosen by the student or students parent/guardian or another person with legal authority to make medical decisions for the student.

The student as successfully completed each requirement of the return to play protocol .

The treating physician has provided written statement that in their professional judgment it is safe for the student to return to play

The student and the students parent/guardian or other person legally authorized to make medical decisions for the student have acknowledged that the student has completed the return to play requirements necessary.

Have provided the treating physician written statement to the person responsible for compliance with the return to play protocol and the person who has supervisory responsibilities.

Have signed a consent form indicating that they have been informed concerning and consent to the student returning to play. Understands the risks of returning to play following a concussion and will comply with the ongoing requirements of the return to play protocol.

Consents to disclosure to appropriate persons under the HIPPA act of 1996 of the doctors written statement and recommendations

Also understands the immunity provisions of section 38.159

Parent sign: _____

Student sign:_____ **Date:** ____/____/____

PREPARTICIPATION MEDICAL HISTORY DONE YEARLY

EXPLAIN YES ANSWERS IN BOX BELOW

YES ANSWERS TO QUESTION 1-6 PHYSICAL REQUIRED

Have you had a illness/injury since last physical Y N
Have you been hospitalized overnight in last year Y N
Have you ever had surgery Y N
Have you ever had testing for the heart ordered by a Physician Y N
Have you ever passed out during or after exercise Y N
Have you ever had chest pain during or after exercise Y N
Do you get tired more quickly than your friends do during exercise Y N
Have you ever had racing of your heart or skipped heartbeats Y N
Have you had high blood pressure/cholesterol Y N
Have you ever been told you have a heart murmur Y N
Has any family member died of heart problems or of sudden unexplained death before age 50 Y N
Has any family member been diagnosed with any heart problems(enlargedheart,longQT,Brugada syndrome,marfan syndrome, abnormal heart rhythm) Y N
Have you had a severe viral infection in last month Y N
Have you ever been denied or had restricted participation by a physician from a heart problem Y N
Have you ever had a head injury/concussion Y N
Have you ever been knocked out or had memory loss Y N
If yes how many times_____
When was the last concussion _____
How severe was each one(explain below)
Have you ever had a seizure Y N
Do you have frequent or severe headaches Y N
Have you ever had numbness tingling in your arms hands legs or feet Y N
Have you ever had a stinger, burner, or pinched nerve Y N
Are you missing any paired organs(eyes, kidneys) Y N
Are you under a doctor's care Y N

Yes answers to any above questions physical reqiured

Are you currently taking any prescription/ non prescription medications or inhaler Y N
Do you have any allergies Y N
Have you ever been dizzy during or after exercise Y N
Do you have any current skin problems Y N
Have you ever become ill from exercising in the heat Y N
Have you ever had any vision problems Y N
Have you ever gotten short of breath during exercise Y N
Do you have asthma Y N
Do you have seasonal allergies Y N
Do you use any special protective equipment or corrective equipment Y N
Have you ever had a sprain strain or swelling from an injury Y N
Have you ever had a fracture dislocation Y N
Have you ever had pain swelling in muscles tendons joints Y N
Do you want to weigh more or less than you do M L
Do you feel stressed Y N
Have you ever been diagnosed or treated for sickle cell disease or sickle cell trait. Y N

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 _____
EXPLAIN YES ANSWERS _____
_____

I HEREBY STATE THAT THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FAILURE TO PROVIDE TRUTHFUL RESPONSES COULD RESULT IN PENALTIES BY THE UIL.

PARENT SIGNATURE_X_____

STUDENT SIGNATUREX_____

MEDICAL HISTORY REVIEWED BY(TRAINER SIGN/PRINT)

_____DATE_____

SUDDEN CARDIAC AWARENESS FORM

Sudden cardiac arrest often occurs without warning
An electrical malfunction causes bottom chamber of heart to beat dangerously fast and disrupts pumping ability of heart. The heart cannot pump blood to the brain, lungs and other vital body organs. The person loses consciousness and has no pulse. Death occurs within minutes if not treated properly.
What causes sudden cardiac arrest?
Conditions present at birth
Inherited conditions of the heart muscle(parents/relatives)
Hypertrophic cardiomyopathy, hypertrophy of left ventricle
Most common cause of death in athletes in US
Arrythmogenic right ventricular cardiomyopathy
Marfan syndrome
Inherited conditions of the electrical system such as long QT catecholaminergic polymorphic ventricular tachycardia and brugada syndrome and other types that run in families
Noninherited but present at birth coronary artery abnormalities aortic valve abnormalities non compaction
Cardiomyopathy Wolfe Parkinson white syndrome
Conditions not present at birth but later in life commotion cordis myocarditis recreational performance enhancing drug use
Idiopathic unknown cause of sudden cardiac arrest even after autopsy
What are the warning signs of sudden cardiac arrest
Fainting blackouts during exercise dizziness unusual fatigue weakness chest pain shortness of breath nausea vomiting
Palpitations(fast heartbeats or skipped beats) family history of sudden cardiac arrest before age 50 any of these symptoms warrant further evaluation by a physician before returning to practice or a game.
What is the treatment for sudden cardiac arrest time is critical call 911 begin CPR use and automated external defibrillator AED What are ways to screen for Sudden cardiac arrest the American heart association recommends pre participation history and physical including 14 important cardiac elements The UIL preparticiaption physical medical history includes all 14 components and is mandatory annually additional screening electrocardiogram
The cardiac section of the uil health and safety website at www.Uil.texas.org provides further cardiac information

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative 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 University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

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 representatives of the school, 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.

I have been provided the UIL Parent Information Manual regarding health and safety issues(concussions) and my responsibilities as a parent/guardian. **I understand that I can get a copy of this manual online at the following web address:** http://www.uil.utexas.edu/athletics/manuals/pdf/parent_information.pdf. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

Your signature below gives authorization that is necessary for the school district, its trainers, coaches, associated physicians and student insurance personnel to share information concerning medical records, medical diagnosis and treatment for your student. I have read the regulations cited above and agree to follow the rules.

HELMET DISCLAIMER: WARNING No helmet can prevent all head and neck injuries a player might receive while participating in their sport. Do not use a helmet to butt , ram or spear an opposing player. This is a violation of the rules and may result in severe head or neck injuries, paralysis, or death to and possible injury to your opponent. Hallsville ISD wil provide the best possible equipment when able for your child to participate in athletics.

MEDICAL EXPENSE/INSURANCE:

HISD purchases a limited benefit policy that covers all student athletes while participating in UIL extracurricular activities. The insurance coverage is SECONDARY or EXCESS which is designed to help pay those expenses not paid or payable by any other insurance. This means that the parent will be required to file with primary insurance first and then after benefits are paid the school insurance will pay on the remaining balance.

The following is important information concerning the UIL athletic coverage:

The policy covers your child only during practices(in season or offseason, competition, and travel to and from uil sanctioned activities.
The policy is a zero deductible and has limited benefit structure. It may not cover 100 percent of the medical bills. It is coordinated with any personal coverage that you may have. Personal insurance is primary and the school policy is secondary. Any remaining balances not covered by either insurance is the responsibility of the parent. Parents will coordinate all bills and claims. HISD IS NOT REPSONSIBLE FOR PAYMENT OF MEDICAL BILLS INCURRED DUE TO INJURY WHILE PARTICIPATING IN UIL ACTIVITIES.

Parents must give personal insurance information to the athletic trainers, team or family doctors and all other health care providers in regards to your child's injury. Parents must notify the athletic trainers prior to all doctors visits, medical procedures, etc or insurance benefits may be forfeited.

GENERAL ELIGIBILITY RULES: BY UIL RULES STUDENTS ARE ELIGIBLE TO PARTICIPATE IN UIL ACTIVITIES IF:

Are not 19 yrs old or older prior to September 1 of the current scholastic year or have not graduated from high school
Are enrolled by the 6th class day of the current school year or have been in attendance 15 calendar days prior to varsity competition. Are full time students in the high school they represent. Initially not enrolled in 9th grade more than 4 years ago. Are meeting academic standards required by state law. Live with their parents inside the school district attendance zone their first year of attendance. If the parents do not reside in the school district attendance zone the student may be eligible if they have been in attendance one calendar year and has not enrolled in another school, no inducement is given to the student to attend the school and is not in violation of local school or TEA policies to attend that school. Students placed by the Texas Youth Comission are covered under custodial residence . Have observed all provisions of the award rule. Have not been recruited. Have not violated any provison of the summer camp rule. Any 10-12 grade student shall not attend any camp in which a 7-12 grade coach from the school attendance zone instructs. 7-9th grade students may attend one camp of such nature.
Have observed all provisions of the amateur athletic rule. No valuable consideration to participate in UIL activities.
Did not change schools for athletic reasons.

I have read, received, and give consent to all the information contained in this packet. DATE_____

X Signature of parent

X Signature of student