## CISD requires an annual physical exam for Athletics, Marching Band, Cheefleading, Drill Team, ROTC and CISD Club Sponsored Athletic Teams. \*\*CISD will not accept physicals or completed paperwork dated prior to April 15, 2022\*\*

2022-2023

| MEDICAL ROYAL PORM must be completed analysis by parent for gavarian) and sudent in order for the fitted in the participate in artificials. These questions are designed to determine if the sudent has developed any ordering in an invest. It is because in the stand the bagging and stand the harmonic on granting in the standard in participate in a recent, it is because in the standard participate in a recent, it is because in the standard participate in a recent in the standard participate in the standard participate in a recent in the standard participate in a recent in the standard participate in a recent     | Student's Name                                                                                                                                                                                                             | Primary Sport                          |             |                   | Number 2022                           | -23 Grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Date of Bi                             | rth            |
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| participation, say illinear or injury should occur that may limit this student's participation, largere to morely the topic of the participation of the part  | 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 |                                        |             | Height: \         | Weight:                               | Pulse:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                        |                |
| After year control of the part  | participation, any illness or injury should occur that may limit this stude school authorities of such illness or injury.                                                                                                  | lent's participation, I agree to noti  | ify the     | e                 | pressure while sitting):              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| bedyer early participations in Ulli processes, permiss or the check up or sports physical?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Any "yes" answer to questions 1, 2, 3, 4, 5, or 6 requires further medic                                                                                                                                                   | al evaluation, which may include o     | a phy:      | sical             |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | Y N            |
| Have you had a medical illess or injury since your last check up or sports physical?  Have you have happstalized overnight in the past year?  Have you ere had surger?  Have you ere had formed the mean careful or have been described by physican.  Have you ere had described in the next ordered by a physican.  Have you ere had described during or after exercise?  Have you ere had described during or after exercise?  Have you ere had described during or after exercise?  Have you ere had described during or after exercise?  Have you ere had described have a dispend herebested?  Have you ere had been dispended and the present manner.  Have you had high blood pressure or high cholesteror?  Have you had high blood pressure or high cholesteror?  Have you had high blood pressure or high cholesteror?  Have you had high blood pressure or high cholesteror?  Have you had high blood pressure or high cholesteror?  Have you had had been important the manner.  Have you have a review view fection for pressure or other ison channelepathy (foregota with the pressure of the p  | before any participation in UIL practices, games, or matches.                                                                                                                                                              | iniropractor, or nurse practitioner    |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| His you been hopitationed overlingth in the pasty year?  A lively oue or the passed out during or after exercits?  His you care that dealing of your heart or skipped heartheast?  His you care had dealing of your heart or skipped heartheast?  His you care had dealing of your heart or skipped heartheast?  His you care had dealing of your heart or skipped heartheast?  His you care had dealing of your heart or skipped heartheast?  His you care had dealing of your heart or skipped heartheast?  His you care had heading of your heart or skipped heartheast?  His you care had heading of your heart or skipped heartheast?  His you care had heading of your heart or skipped heartheast?  His you care had heading of your heart or skipped heartheast?  His you care had reading of your heart or skipped heartheast?  His you care had reading of your heart or skipped heartheast?  His you care had reading of your heart or skipped heartheast?  His you want for compressing the skipped heartheast?  His you want or want for your care of your gent for your gent for your care of your gent for your gent for your gent for your gent for your care of your your for your care of your gent for your care of your gent for your  |                                                                                                                                                                                                                            | or sports physical?                    |             |                   |                                       | (Normal)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Abnormal Findings                      | initials &     |
| 9. Have you ever had advoir testing for the heart ordered by a physician law you ever had chest pain during or after exercise?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| His You over passed out during or after exercice?  Live you care that other stips during or after exercice?  De you get titled more quickly than your friends do furing exercise?  De you get beef more quickly than your friends do furing exercise?  His You was the his bood pressure or high cholesterol?  His You over been told you have a heart murrar?  His as you have heart heart murrar?  His as you have heart murrar?  His as you have heart murrar?  His as you family member been diagnosed with enlarged heart, (dilated cardiomyepathy), hypertroptic cardiomyepathy (long for your down and heart righthm?  His as you family member been diagnosed with enlarged heart, (dilated cardiomyepathy), hypertroptic cardiomyepathy (long for your down and heart righthm?  His as you family member been diagnosed with enlarged heart, (dilated cardiomyepathy), hypertroptic cardiomyepathy (long for your down and heart righthm?  His as you family the properties of the properties  |                                                                                                                                                                                                                            |                                        |             |                   |                                       | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1000                                   |                |
| Do you get tired more quickly than your friends of ouring exercise?  Here you set had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had high blood pressure or high chalestero?  Here you had severe via infection fire completing our monousceds; which the iss month?  Do you have an ingering effects from a COVID disprosit?  How you care had head injury or concussion?  How you care had a stringe bloom or the bod of this pape?  How you care had a stringe bloom or personal head the high or you care had a stringe bloom or personal head head injury or placet concussion?  How you care had numbers or the dispression or personal head head injury or placet concussion?  How you care had numbers or the adacters?  How you care had numbers or the adacters?  How you care had numbers or the adacters?  How you care head charge bloom or non-prescription (see the country in many personal head the high or placet and the high of the high or   | Have you ever passed out during or after exercise?                                                                                                                                                                         |                                        |             |                   | Lymph Nodes                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Have you have had racing of your heart or skipped heartheats?  Have you seek been fold you have a heart murran?  Have you seek been fold you have a heart murran?  Have you seek been fold you have a heart murran?  Have you seek been fold you have a heart murran?  Have you seek been fold you have a heart murran?  Have you have fold of heart problems or it sudden exampled death before gas 93?  Has any family member been diagnosed with enlarged heart, (dilated cardiomycapathy), hypertophic cardiomycapathy in (dilated for heart problems)  Have you seek had head injury or activities for any heart problems?  Has a phylician ever denied or restricted your participation in activities for any heart problems?  Have you ever had a head injury concussion?  How severe we each nore? (Explain on the book of this gogo)  Have you ever had a sead furly.  How severe we each nore? (Explain on the book of this gogo)  Have you ever had a sead graph, burner, or pinched nerve?  A rey our instingt any partied organs.  A rey our instingt any partied organs.  A rey our instingt any partied organs.  A rey our winding any partied organs.  A rey our winding any partied organs.  Book you have any allegies (for example, to polete, medicine, food, or stinging insects)?  Boy you have any allegies (for example, to polete, medicine, food, or stinging insects)?  Have you ever that distribution of the reservation of the properties   |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| New you had high blood pressure or high cholesterol?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                            |                                        |             |                   |                                       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                |
| has any family member been diagnosed with charged heart, (dilated cardiomyopathy), hypertophic cardiomyopath, long of yndrome or their incharmingshift (Francisco).  Has any family member been diagnosed with charged heart, (dilated cardiomyopathy), hypertophic cardiomyopath, long of yndrome or or their incharmingshift (Francisco).  Has any family member been diagnosed with charged heart, (dilated cardiomyopathy), hypertophic cardiomyopathy or a bottomy of yndrome or or their incharmingshift (Francisco).  Has any family member been diagnosed with charged heart, (dilated cardiomyopathy), hypertophic cardiomyopathy or yndromy or yndro  | Have you had high blood pressure or high cholesterol?                                                                                                                                                                      |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| death before see \$07  Misa any family member been disgnosed with enlarged heart, (dilated cardiomyopathy), hypertophic cardiomyopathy, long QT syndrome or drive for channelpathy (Brugada hypertophic cardiomyopathy, long QT syndrome or drive for channelpathy (Brugada hypertophic cardiomyopathy, long QT syndrome or drive for channelpathy (Brugada hypertophic cardiomyopathy, long QT syndrome or drive for channelpathy (Brugada hypertophic cardiomyopathy, long QT syndrome or drive for channelpathy (Brugada hypertophic cardiomyopathy, long QT syndrome or drive for cardiomyo |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada's syndrome, etc.). Marfain's syndrome or severe head a head injury or concussion.  Have you ever had a head injury or concussion.  Have you ever had a head injury or concussion.  My etc. how mony times?  Do you have frequent or severe headacher?.  Have you ever had a stringe, burner, or pincted nerve?  She you currently under a doctor's care for a specific medical issue?  Have you ever had a stringe, burner, or pincted nerve?  She you currently under a doctor's care for a specific medical issue?  Bo by ou have any allergies (for example, to polite, medicine, food, or stringing insciss)?  Have you ever been dizzy during or after exercise?  New you ever been dizzy during or after exercise?  New you ever been dizzy during or after exercise?  New you have any allergies (for example, to polite, medicine, food, or stringing insciss)?  Have you ever been dizzy during or after exercise?  New you have asthma?  Do you use any special prolited the exercise?  Have you been for forcitized any other problems with your eyes or vision?  Have you ever had a specin, strain, or swelling after injury?  Have you been for forcitized any other problems with your eyes or vision?  Have you been for forcitized any other problems with your eyes or vision?  Have you ever had a spenial, strain, or swelling after injury?  Have you been for forcitized any other problems with your eyes or vision?  Have you been for forcitized any other problems with pain or swelling in muscles, tendons, bonce, or joints?  If yet, cleed oppropriate box and explain below.  Do you have asthma?  Do you have an  |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| syndrome, etc.), Marfan's syndrome, or alternatively make the syndrome, or alternatively make the syndrome, or alternative more syndromes or monomicosis within the last month?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                            |                                        |             |                   | Pulses                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Have you had a severe vial infection (for example, mycordrise or monosucleosity within the last month?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                            |                                        | п           | п                 |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Has a physician ever denied or restricted your participation in activities for any heart problems?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Have you had a severe viral infection (for example, myocarditis or mon                                                                                                                                                     | onucleosis) within the last month?     | . 🗆         |                   |                                       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                |
| 4. Have you ever had a head injury or concussion?    Have you ever had a head injury or become unconscious, or lost your memory?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                            |                                        |             |                   | · · · · · · · · · · · · · · · · · · · | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                |
| Have you ever been knocked out, become unconscious, or lost your memory?    flyes, how many times?   When was your last concussion?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | +              |
| # When was your rest and positives or position from the service of this page.    A rey ou currently under a doctor's care for a specific medical issue?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Have you ever been knocked out, become unconscious, or lost y                                                                                                                                                              | our memory?                            | . $\square$ |                   | (arachnodactyly, pectus escavatur     | n                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        | 1 1            |
| Have you ever had a striure?    Have you ever had a striure?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | If yes, how many times? When was your last of                                                                                                                                                                              | concussion?                            | _           |                   | FOL 10 AM 0 1000 10 1000              | aaste Muscul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | oskeletal 2000 och 1000                | <b>医</b>       |
| Do you have frequent or severe headaches?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                            |                                        | . $\square$ |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Have you ever had a stringer, burner, or pinched nerve?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Do you have frequent or severe headaches?                                                                                                                                                                                  |                                        | . 🗆         |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 5. Are you currently taking any paried organs? 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using a 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, orne, warts, fungus, or bilisters)? 11. Have you ever been dizzy during or after exercise? 12. Have you and any problems with your eyes or vision? 13. Have you ever become ill from exercising in the heat? 14. Have you ever been diary problems with your eyes or vision? 15. Have you ever gotten unexpectedly short of breath with secrcise? 16. Do you have easonal allergies that require medical treatment? 17. Have you be read as prain, strain, or swelling after injury? 18. Have you breath ad a sprain, strain, or swelling after injury? 19. When was you first merit on the well of the strain o  |                                                                                                                                                                                                                            |                                        |             |                   | Shoulder/Arm                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 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 ditzy during or after exercise?  9. Have you ever been ditzy during or after exercise?  10. Do you have any currents kin problems (for example, inching, rashes, acne, worts, fungus, or blisters)?  11. Have you ever been membered and any problems in problems (for example, inching, rashes, acne, worts, fungus, or blisters)?  12. Have you have sastonal allergies that require medical treatment?  13. Have you ever gotten unexpectedly short of breath with exercise?  14. Do you have sastonal allergies that require medical treatment?  15. Do you have sastonal allergies that require medical treatment?  15. Have you ever had a sprain, strain, or swelling after injury?  16. Have you broken or fractured any bones or dislocated any joints?  17. Have you though expropriet be known of explain believed any bones or dislocated any joints?  18. Have you though one or less than you do now?  19. Yes, check appropriate box and explain believed any bones or dislocated any joints?  19. Yes, check appropriate box and explain believed in must be filled in and signed by either of Physician Assistant Examiners, a Registered Nurse recommendations:  16. Do you should be stressed out?  17. Do you feel stressed out?  18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?  19. When was your most recent menstrual period?  19. When was your most recent menstrual period?  19. When was your most recent menstrual period?  19. When was your first menstrual period?  19. When was your most recent menstrual period?  20. Are you missing a testicle?  21. Do you have testicular swelling or masses?  22. Do you have testicular swelling or masses?  23. An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening in the proposition o  |                                                                                                                                                                                                                            |                                        |             |                   | Elbow/Forearm                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| pills or using an inhalter?  Does this allergy require an EpiPen?  Jean Have you were been dizzy during or after exercise?  Do you have expecting in mexicing in the heat?  Do you have expecting in the mexicing in the heat?  Li Have you were protein unsepticed synchro for breath with exercise?  Do you have sastma?  Do you have sastma?  Do you have sastmal in the heat?  Do you have you have problems with pain or swelling in muscles, tendons, bones, or joints?  Have you have problems with pain or swelling in muscles, tendons, bones, or joints?  Have you have problems with pain or swelling in muscles, tendons, bones, or joints?  Have you have problems with pain or swelling in muscles, tendons, bones, or joints?  Have you have problems with pain or swelling in muscles, tendons, bones, or joints?  Have you have problems with or treated for sickle cell disease?  Do you want to weigh more or less than you do now?  Do you feel stressed out?  Do you are been diagnosed with or treated for sickle cell disease?  Do you feel stressed out?  Do you have the heat?  Do you have the   |                                                                                                                                                                                                                            |                                        | 🗆           |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
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| Substitute   Substitute   Station-based examination only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 10. Do you have any current skin problems (for example, tiching, rashes, acne, warts, fungus, or blisters)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Does this allergy require an EpiPen?                                                                                                                                                                                       |                                        | 🛚           |                   |                                       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                |
| 11. Have you had any problems with you eyes or vision? 12. Have you had any problems with you eyes or vision? 13. Have you had any problems with you eyes or vision? 14. Do you have sasaonal allergies that require medical treatment? 15. Have you had any problems or fractured any bones or dislocated any joints? 16. Have you ever had a sprain, strain, or swelling after injury? 17. Have you broken or fractured any bones or dislocated any joints? 18. Have you broken or fractured any bones or dislocated any joints? 19. More than any other problems with pain or swelling in muscles, tendons, bones, or joints? 19. More than any other problems with pain or swelling in muscles, tendons, bones, or joints? 19. More than any other problems with pain or swelling in muscles, tendons, bones, or joints? 19. When was your first lend   Cheb   Chest   Hand   Shin/Coff   10. Do you lead the stressed out? 10. Do you lead the stressed out? 11. Have you ever been diagnosed with or treated for sickle cell disease? 12. Do you want to weigh more or less than you do now? 13. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? 14. How many periods have you had in the last year? 15. When was your most recent menstrual period? 16. When was your most recent menstrual period? 17. When was your most recent menstrual period? 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? 19. When was your most recent menstrual period? 20. Are you missing a testicle? 21. Do you have testicular swelling or masses? 22. Are you missing a testicle? 23. An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening on the purpose of the period of the p  | Have you ever been dizzy during or after exercise?      Do you have any current skin problems (for example, itching, rash)                                                                                                 | es. acne. warts. funaus. or blisters)? |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ************************************** |                |
| 13. Have you ever gotten unexpectedly short of breath with exercise?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. Have you ever become ill from exercising in the heat?                                                                                                                                                                  |                                        | 🛚           |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | * Station-based ex                     | amination only |
| Do you have asthma?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 12. Have you had any problems with your eyes or vision?                                                                                                                                                                    |                                        | 📙           |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Do you have seasonal allergies that require medical treatment?    Do you use any special protective or corrective equirement or devices that aren't usually used for your activities or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Do you have asthma?                                                                                                                                                                                                        |                                        | 🗆           |                   | ☐ Cleared after con                   | npleting eva                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | aluation/rehabilitatio                 | on for:        |
| for your activities or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?  15. Have you broken or fractured any bones or dislocated any joints? Have you broken or fractured any bones or dislocated any joints? Have you broken or fractured any bones or dislocated any joints? If yes, check appropriate box and explain below. Heded   Elbow   Hip                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Do you have seasonal allergies that require medical treatment?                                                                                                                                                             |                                        | 🗆           |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| retainer on your teeth, hearing aid)?    Have you broken or fractured any bones or dislocated any joints?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 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.  Hed   Elbow   Hip   Neck   Forearm   Thigh   Board of Physician Assistant licensed by a State   Board of Physician Assistant licensed by a State   Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse precognized as an Advanced Practice Nurse by the Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the 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:  In formal properties of Physician Assistant Examiners, a Registered Nurse Practice Nurse practice, and the Information Advanced Practice Nurse practice, a  | retainer on your teeth, hearing aid)?                                                                                                                                                                                      |                                        | 🗆           |                   | Reason:                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 15. Have you ever had a sprain, strain, or swelling after injury?                                                                                                                                                          |                                        | 🗆           |                   | Pacammandatio                         | nc:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                |
| If yes, check appropriate box and explain below.    Had     Elbow   Hip   Neck   Forearm   Thigh   Shoulder   Finger   Ankle   Upper Arm   Foot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Have you broken or fractured any bones or dislocated any joints  Have you had any other problems with pain or swelling in musc                                                                                             | Recommendatio                          | 113.        |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Back   Wrist   Knee   Chest   Hand   Shin/Colf   Either a Physician Assistant licensed by a State   Shoulder   Finger   Ankle   Upper Arm   Foot   Foot   Foot   Finger   Ankle   Upper Arm   Foot      | If yes, check appropriate box and explain below.                                                                                                                                                                           |                                        |             |                   | 2                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| Shoulder   Finger   Ankle   Upper Arm   Foot     10. Do you want to weigh more or less than you do now?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                            |                                        |             |                   | 9 ****                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | 500 800        |
| 16. Do you want to weigh more or less than you do now?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ☐ Shoulder ☐ Finger ☐ Ankle ☐ Upper Arm ☐                                                                                                                                                                                  | ] Foot                                 |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 16. Do you want to weigh more or less than you do now?                                                                                                                                                                     |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 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. Are you missing a testicle?  21. Do you have testicular swelling or masses?  An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.  Explain all "yes" answers on the back of this page.  This medical history form was reviewed by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 17. Do you feel stressed out?                                                                                                                                                                                              | t or sickle cell disease?              | L           | 1 1               |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| 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?  What was the longest time between periods in the last year?  Males Only  20. Are you missing a testicle?  21. Do you have testicular swelling or masses?  An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.  Explain all "yes" answers on the back of this page.  This medical history form was reviewed by:  This medical history form was reviewed by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | - Ver                                                                                                                                                                                                                      |                                        |             | _                 |                                       | the state of the s | health care practit                    | tioner, will   |
| 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. Are you missing a testicle?  21. Do you have testicular swelling or masses?  An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.  Explain all "yes" answers on the back of this page.  This medical history form was reviewed by:  Name (print/type):  Address:  Phone Number:  Physician's Signature:  This form, in its entirety, must be on file before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or agames/matches or performances/competitions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6                                                                                                                                                                                                                          |                                        |             |                   | пот ве ассертеа.                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
| How many periods have you had in the last year?  What was the longest time between periods in the last year?  Males Only  20. Are you missing a testicle?  21. Do you have testicular swelling or masses?  An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.  Explain all "yes" answers on the back of this page.  Name (print/type):  Address:  Phone Number:  Physician's Signature:  This form, in its entirety, must be on file before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or after school, (both in-season and out-of-season) or games/matches or performances/competitions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | VANUE 96,000 00 100,000 00 10 10                                                                                                                                                                                           |                                        |             |                   |                                       | on:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                        |                |
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| What was the longest time between periods in the last year?  Males Only  20. Are you missing a testicle?  21. Do you have testicular swelling or masses?  An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.  Explain all "yes" answers on the back of this page.  This medical history form was reviewed by:  Address:  Phone Number:  Physician's Signature:  This form, in its entirety, must be on file before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or after school, (both in-season and out-of-season) or games/matches or performances/competitions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | How many periods have you had in the last year?                                                                                                                                                                            |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
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| 21. Do you have testicular swelling or masses?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                            |                                        |             | Phone Number:     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
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| Explain all "yes" answers on the back of this page.  For school use only.  This medical history form was reviewed by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                            |                                        |             |                   | student parti                         | cipates in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | any practice, befo                     | re, during or  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Explain all "yes" answers on the back of this page.                                                                                                                                                                        |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | petitions.                             |                |
| Printed name Date Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | For school use only.  This medical history form was reviewed by:                                                                                                                                                           |                                        |             |                   |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        |                |
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The Corroe Independent School District (District) is an equal opportunity educational provider and employer does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in educational programs or activities that it operates or in employer matters. The District is required by Title VI and Title VII of the Civil Rights Act of 1964, as amended, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, as amended, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, as well as Board policy not to discriminate in such a manner.

Controe ISD is committed to providing access to all individuals, including those with disabilities, seeking information on our website. If you use assistive technology (such as a screen reader, eye tracking device, voice recognition software, etc.) and are experiencing difficulty accessing information on this site, please contact the Director of Communications at: 3205 W. Davis Controe, Toxas 77304 (935) 703-7752