



PREPARTICIPATION PHYSICAL EVALUATION FORM – MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and participant in order for the player to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Player's Name: (print) _____ Gender _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below. Circle questions you don't know the answers to. Any Yes answer to questions 1-6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician's assistant, chiropractor, or nurse practitioner is required before any participation in KYF practices, games, or matches**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or Devices that aren't usually used for your sport or position (for example: knee brace special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member been diagnosed with enlarged heart (dilated cardiomyopathy), hyperrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
When was the last concussion? _____			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)	<input type="checkbox"/>	<input type="checkbox"/>	18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only:		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period?	_____	
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?	_____	
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another?	_____	
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year?	_____	
7. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year?	_____	
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.		
10. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	**Explain "Yes" ANSWERS HERE (attach additional sheet, if necessary):		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Katy Youth Football does not assume any responsibility in case an accident occurs. If, in the judgment of any representative of the league, the above participant should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said participant by any physician, athletic trainer, nurse, or trained league representative. I do hereby agree to indemnify and save harmless the league and any league or team representative from any claim by any person on account of such care and treatment of said participant.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the participant in question to penalties determined by KYF. I, as parent/guardian of said KYF player/cheerleader hereby give permission for said child to participate in any and all activities sponsored by Katy Youth Football.
Parent/Guardian Signature: _____ Date: _____



PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Player's Name: (print) _____ Gender _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (_____/_____, ____/_____)
 Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to participation in any KYF® sport **annually**.

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practices or games.