



PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY



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

STUDENT NAME (PRINT): _____
 GENDER: _____ AGE: _____ DATE OF BIRTH: _____
 HOME ADDRESS: _____
 HOME PHONE: _____ PARENT CELL PHONE: _____
 SCHOOL: _____ GRADE LEVEL: _____
 PERSONAL PHYSICIAN: _____
 PHYSICIAN PHONE: _____

In case of emergency contact:

NAME: _____ RELATIONSHIP: _____
 HOME PHONE: _____ CELL PHONE: _____

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last checkup or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you get tired more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has any family member or relative died of heart problems before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has any family member or relative died of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any family member been diagnosed with Hypertonic Cardiomyopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has any family member been diagnosed with Long QT Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has any family member been diagnosed with Marfan's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had a severe viral infections (myocarditis, mononucleosis, etc) in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has a physician ever denied or restricted your participation in sports for any heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever experienced a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had numbness in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are you presently under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you currently taking any prescription or nonprescription medications or inhalers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been dizzy before or during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever become ill after exercising or working in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 32. Have you ever had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you use any special protective or corrective equipment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Have you ever had a sprain, strain or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever broken or fractured any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please check the appropriate box and explain on separate sheet of paper.

- | | | | | |
|--------------------------------|------------------------------------|---------------------------------|-------------------------------------|-------------------------------|
| Head <input type="checkbox"/> | Shoulder <input type="checkbox"/> | Wrist <input type="checkbox"/> | Thigh <input type="checkbox"/> | Foot <input type="checkbox"/> |
| Neck <input type="checkbox"/> | Upper Arm <input type="checkbox"/> | Hand <input type="checkbox"/> | Knee <input type="checkbox"/> | |
| Back <input type="checkbox"/> | Elbow <input type="checkbox"/> | Finger <input type="checkbox"/> | Shin/ Calf <input type="checkbox"/> | |
| Chest <input type="checkbox"/> | Forearm <input type="checkbox"/> | Hip <input type="checkbox"/> | Ankle <input type="checkbox"/> | |

- | | | |
|---|--------------------------|--------------------------|
| 41. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you lose weight regularly to meet weight requirements for you Extra-Curricular Activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Females Only

- | | |
|---|------------|
| 45. When was your first menstrual period? | _____ |
| 46. When was your most recent menstrual period? | _____ |
| 47. How much time elapses from the start of one period to the start of another? | _____ days |
| 48. How many periods have you had in the last year? | _____ |
| 49. What was the longest time between period in the last year? | _____ days |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of accident still remains. Neither the **Texas Association of Private and Parochial Schools**, nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, in between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.

STUDENT SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN NAME (PRINT): _____

PARENT SIGNATURE: _____ DATE: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____



PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION



STUDENT NAME (PRINT): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT: _____

PULSE: _____ BLOOD PRESSURE: ____/____ (____/____/____)

Brachial blood pressure while sitting

VISION: R 20/____ L 20/____ CORRECTED: YES ____ NO ____ PUPILS: EQUAL ____ UNEQUAL: ____

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation in the first and third years of high school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			

*Initials for station –based examination only

MUSULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other			

CLEARANCE

- Cleared for participation
- Cleared for participation after completing evaluation/ rehabilitation for: _____
- Not cleared for participation

Recommendations: _____

Provider Name: _____ Date of Examination: _____

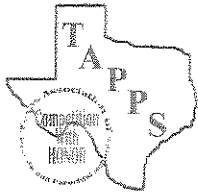
Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

Texas Association of Private and Parochial Schools

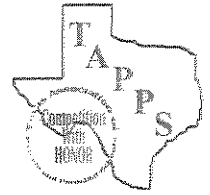
STUDENT ACKNOWLEDGMENT OF RULES



Student Name:

Date of Birth: Current Grade:

TAPPS School



This form must be signed by both the students and parent/guardian and be on file at the TAPPS member school prior to the student participating in any Inter-scholastic contest.

According to the rules outlined in the TAPPS Constitution and By-Laws, by initial of the following, we attest that the above named student:

Student Parent

- has not reached 19 years of age prior to September 1 on the current school year.
- has not graduated from high school.
- did not enroll in the **NINTH GRADE** more than 4 years ago, nor **TENTH GRADE** more than three years ago
- is a full time day student taking at least four core courses on the campus of the TAPPS member school
- has not represented a college in a contest
- are not in violation of the TAPPS Awards Rule
- is in compliance with the TAPPS academic eligibility rules as presented in the TAPPS Constitution, By-Laws, and Contest rules.

- did not** transfer to the TAPPS member school from another high school for the current school year
- did** transfer to the TAPPS member school for the current school year.

In order to be eligible for Varsity Participation, the student must have transferred to the TAPPS member school prior to the following deadlines. By initial, the parent/guardian attests that the following deadline was met.

- September 8, 2010** **FALL SPORT DEADLINE - Cross Country, Fall Soccer, Football, Volleyball**
- December 8, 2010** **WINTER SPORT DEADLINE - Basketball, Swim and Dive, Winter Soccer, Wrestling**
- February 23, 2011** **SPRING SPORT DEADLINE - Baseball, Golf, Softball, Tennis, Track and Field**
- is in compliance with the Transfer Rules presented in the TAPPS By-Laws Section 104 and has not "followed" any coach this current school year from a previous school.

- is in compliance with By-Laws Section 136 and 139 in that the student shall not play for a coach from the TAPPS member school he/she is attending on a non-school team from the beginning of TAPPS activities in August until the last day of the current school year as determined by the TAPPS member school.
- is living with their parents, attending an approved TAPPS Boarding School, or has been received approval to participate in TAPPS Extra-Curricular activities while living with a guardian as outlined in the TAPPS By-Laws.
- has been presented the information presented in the TAPPS By-Laws Section 87 and is in compliance with all rules and regulations pertaining to the Recruiting, Inducement, and Tampering of students.

Student Name:

Parent

I hereby give my consent for the above named student to compete in TAPPS approved contests and travel with the director or other representative of the school on any trips. Neither TAPPS nor the member school assumes any responsibility in case of accident or injury.

I hereby agree to be responsible for the safe return of all equipment owned by the school and issued to the above named student.

If, in the judgment of any representatives of the school, the above named student needs immediate care and treatment as a result of injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, trainer, nurse, hospital or school representative; and do hereby agree to indemnify and save harmless TAPPS, TAPPS Staff, TAPPS Executive Board, TAPPS Representatives, the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I understand that I may film or video any game in which my son/daughter participates, but the film or video may not be viewed by the athlete or coaches until the game is over.

I understand that I can not film or video tape any contest in which my son/daughter is not participating without the written permission of both schools involved in the contest.

I understand that if my son/daughter is disqualified (ejected) from a contest, that the penalty includes a fine of at least \$50 being assessed to the school and a one (1) game suspension for my child.

I understand that if my son/daughter is disqualified (ejected) from additional contests, that the Athletic Executive Committee may impose additional penalty to the school and student.

I attest that my son/daughter will abide by all TAPPS Rules as presented in the TAPPS Constitution, By-Laws and Contest Rules.

I understand that if my son/daughter is not in compliance with the TAPPS Constitution, By-Laws and Contest Rules that the eligibility of my son/daughter and the teams involved may be subject to sanctions and penalty.

I understand that the executive management, control and final authority of this association (TAPPS) rests with the TAPPS Executive Board.

We hereby attest that the information presented on this form is correct as indicated by the initials present beside each item.

Student Signature

Date

Parent Signature

Date

Parent Name

Parent Address:

**DO NOT SEND THIS FORM TO THE TAPPS OFFICE OR DISTRICT PRESIDENT UNLESS REQUESTED.
MUST BE KEPT ON FILE AT THE MEMBER SCHOOL.**

PARENT AND STUDENT NOTIFICATION STERIOD USE AGREEMENT FORM

State law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.

State law requires that only a medical doctor may prescribe a steroid for a person.

State law provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person in good health is not a valid medical purpose.

Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

HEALTH CONSEQUENCES ASSOCIATED WITH ANABOLIC STEROIDS

(source: National Institute on Drug Abuse)
<http://www.nida.nih.gov/infofacts/steroids.html>

For boys and men - shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts, increased risk for prostate cancer.

For girls and women - growth of facial hair, male-pattern baldness, changes in or cessation of the menstrual cycle, enlargement of the clitoris, deepened voice.

For adolescents - growth halted prematurely through premature skeletal maturation and accelerated puberty changes. This means that adolescents risk remaining short for the remainder of their lives if they take anabolic steroids before the typical adolescent growth spurt.

For all ages - potentially fatal liver cysts and liver cancer; blood clotting, cholesterol changes, and hypertension which can promote heart attack and stroke; and acne. Available evidence may suggest that anabolic steroid abuse, particularly in high doses, promotes aggression that can manifest as fighting, physical and sexual abuse, and property crimes. Upon stopping anabolic steroids, some abusers may experience symptoms of depressed mood, fatigue, restlessness, loss of appetite, insomnia, headaches, muscle and joint pain and the strong desire to return to the use of anabolic steroids.

For injectors - infections resulting from the use of shared needles or non-sterile equipment, including HIV / AIDS, hepatitis B and C, and infective endocarditic, a potentially fatal inflammation of the inner lining of the heart. Bacterial infections can develop at the injection site, causing pain and abscess.

STUDENT CERTIFICATION

I have read the above information and agree that I will not use illegal anabolic steroids.

Student Signature

Date

PARENT / GUARDIAN CERTIFICATION

I have read the above information and agree to my knowledge my student will not use illegal anabolic steroids.

Parent / Guardian Signature

Date



**Northeast Christian Academy
Athletics
Parent or Guardian's Permit and Medical Consent Form**

I hereby give my consent for the student athlete/team manager, _____, Grade _____, to participate in Northeast Christian Academy approved sports and go with the coach or other representative of the school on any trips. The above named student is my child, and is now under my control and custody. I authorize Northeast Christian Academy and its representatives to consent to obtain emergency medical treatment for my child in case of any illness or injury in connection with a school activity or school trip. Such treatment to be administered by such physicians, other medical personnel, hospitals, and/or clinics as may be selected by Northeast Christian Academy or its representative. I hereby assume responsibility for such professional services.

I hereby grant permission for Northeast Christian Academy to administer Tylenol, Advil, generic form, or similar nonprescription medications as needed.

Parent note (if needed): _____

It is understood that NCA assumes no responsibility in case an accident occurs. The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the student athlete.

The student athlete has our permission to be transported by his/her parent or guardian, approved chaperone, or NCA bus, to or from away games as needed. The student athlete must check in/out with coach before leaving for any games, etc. The parents/guardians release NCA from responsibility if any accident occurs.

Personal Physician: _____ Phone Number: _____

Hospital Preference: _____

Special Medical Conditions: _____

Drug Allergies: _____ Date of last Tetanus Shot: _____

Mother Name: _____ Phone: _____

Father Name: _____ Phone: _____

Emergency Contact (If parent can not be reached): _____

Relationship: _____ Phone: _____

Please complete the following information or attach a copy of your medical insurance card:

Medical Insurance Carrier: _____ Group # _____

Name of Insured: _____ ID# _____

Provider Phone Number: _____ Eligibility Phone Number: _____

Parent/Guardian Signature: _____ Date: _____