

**Electronic 2017-2018 KLEIN ISD EMERGENCY CONTACT AND PHYSICAL FORM**  
 Page 1 of 2 ALL INFORMATION IS REQUIRED \*\*DO NOT LEAVE ANY BLANKS \*\*PRINT LEGIBLY WITH BLUE OR BLACK INK\*\*

Student's Last Name / Student's First Name / Student's Middle Name

KISD Student ID # Gender Age Date of Birth 2017-18 GRADE

Parent/Guardian 1 FULL Name (include last name) / Parent/Guardian 1 – Cell Phone / Parent/Guardian 1 – E-MAIL (PRINT)

Emergency Contact FULL Name (include last name) / Emergency Contact – Cell Phone / Relation of Emergency Contact

Allergies to medication or other (please list): \_\_\_\_\_

Any medications taken regularly (please list): \_\_\_\_\_

Any medical concerns that should be noted: \_\_\_\_\_

List all Surgeries: \_\_\_\_\_

Sickle Cell/ Trait: YES / NO Diabetes: YES / NO Epilepsy/ Seizure Disorder: YES / NO

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. I hereby state that, to the best of my knowledge, all my answers to the questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL & KISD.

Parent/Guardian Sign (required): \_\_\_\_\_ Student Sign (required): \_\_\_\_\_ Date: \_\_\_\_\_

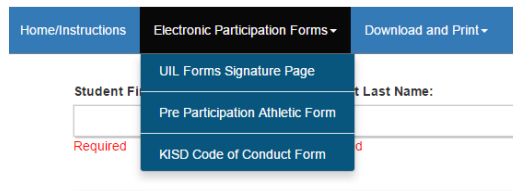
**ONLINE PAPERWORK INSTRUCTIONS**

Parents,

To complete the electronic online forms follow the instructions:

- Access the Klein Forest high school webpage (<http://kleinforest.kleinisd.net/>)
- Select **ATHLETICS**
- Drop down **ATHLETIC FORMS**
  - Click on **ACCESS ONLINE PAPERWORK** to complete forms electronically.
- You will need to **CREATE A NEW ACCOUNT** in order to proceed.

**1st** After your account has been created you will have access to completing your forms online. First, access the electronic participation forms by highlighting over the section at the top of your page.



**2nd** You may access each form by clicking the link provided. By checking the boxes you acknowledge that you read, understand, and agree to the forms.

- 1. Acknowledgement of Rules
- 2. Concussion Acknowledgement Form
- 3. Parent/Student Steroid Agreement Form
- 4. Sudden Cardiac Arrest Awareness Form

**IMPORTANT!**

- If all necessary information is not provided, you will not be able to submit the form for approval.
- Complete the medical history section and take the form to a doctor (MD) to get the pre-participation physical.
- **Please verify that the doctor has dated and signed the form.**
- After all steps have been completed, please turn your form in to your campus Athletic Trainer or Intermediate Head Coach.
- You will receive a confirmation email once the online forms have been approved.

Thank you for your help,  
 Klein ISD Athletic Staff

Student's Name: \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**STUDENT – PARENT/GUARDIAN SECTION**

This MEDICAL HISTORY FORM must be completed annually by parent/guardian and student in order for the student 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. **Explain all "Yes" answers. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation, which may include a physical examination.** Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches.

	YES	NO
1. Have you had a <b>medical illness or injury</b> since your last check up or sports physical?	0	0
2. Have you been <b>hospitalized</b> overnight in the past year?	0	0
Have you ever had <b>surgery</b> ?	0	0
3. Have you ever had prior <b>testing for the heart</b> ordered by a physician?	0	0
Have you ever <b>passed out</b> during or after exercise?	0	0
Have you ever had <b>chest pain</b> during or after exercise?	0	0
Do you get tired more quickly than your friends do during exercise?	0	0
Have you ever had <b>racing of your heart or skipped heartbeats</b> ?	0	0
Have you had <b>high blood pressure or high cholesterol</b> ?	0	0
Have you ever been told you have a <b>heart murmur</b> ?	0	0
Has any <b>family member</b> or relative died of <b>heart problems</b> or of sudden unexpected death before age 50? WHO:	0	0
Has any <b>family member</b> been diagnosed with enlarged heart (dilated cardiomyopathy), Hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? WHO:	0	0
Have you had a severe <b>viral infection</b> (for example, myocarditis or mononucleosis) within the last month?	0	0
Has a physician ever denied or restricted your participation in sports for any heart problems?	0	0
4. Have you ever had a <b>head injury or concussion</b> ?	0	0
Have you ever been <b>knocked out, become unconscious, or lost your memory</b> ?	0	0
If yes, how many <b>times</b> ? _____ When was the last <b>concussion</b> ? _____		
How severe was each one? (Explain) _____		
Have you ever had a <b>seizure</b> ?	0	0
Do you have frequent or severe <b>headaches</b> ?	0	0
Have you ever had <b>numbness or tingling</b> in your arms, hands, legs, or feet?	0	0
Have you ever had a <b>stinger, burner, or pinched nerve</b> ?	0	0
5. Are you missing any <b>paired organs</b> ?	0	0
6. Are you under a doctor's <b>care</b> ?	0	0
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or <b>pills or using an inhaler</b> ?	0	0
8. Do you have any <b>allergies</b> (for example, to pollen, medicine, food, or stinging insects)?	0	0
9. Have you ever been <b>dizzy</b> during or after exercise?	0	0
10. Do you have any current <b>skin problems</b> (for example, itching, rashes, acne, warts, fungus, or blisters)?	0	0
11. Have you ever become ill from exercising in the heat?	0	0
12. Have you had any problems with your <b>eyes or vision</b> ?	0	0
13. Have you ever gotten unexpectedly short of breath with exercise?	0	0
Do you have <b>asthma</b> ?	0	0
Do you have <b>seasonal allergies</b> that require medical treatment?	0	0
14. Do you use any <b>special protective or corrective equipment</b> 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)?	0	0
15. Have you ever had a <b>sprain, strain, or swelling after injury</b> ?	0	0
Have you broken or fractured any bones or dislocated any joints?	0	0
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below	0	0
<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot <input type="checkbox"/> Chest		
16. Do you want to weigh more or less than you do now?	0	0
Do you lose weight regularly to meet weight requirements for your sport?	0	0
17. Do you feel stressed out?	0	0
18. Have you ever been diagnosed with/or treated for <b>sickle cell trait or disease</b> ?	0	0
19. <b>Females Only:</b> When was your <b>first menstrual period</b> ?		
When was your <b>most recent menstrual period</b> ?		
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?		

**MEDICAL EXAMINER SECTION**

As a minimum requirement this PHYSICAL EXAMINATION FORM *must* be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It must be completed if there are "yes" answers to specific questions on the student's MEDICAL HISTORY FORM in the left column. **\*KISD requires an annual physical exam.**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_

BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ : \_\_\_\_\_ / \_\_\_\_\_ )

Brachial Blood Pressure while sitting \_\_\_\_\_

Vision: R – 20/ \_\_\_\_\_ L – 20/ \_\_\_\_\_ Corrected: Y N \_\_\_\_\_

Pupils: Equal/Unequal \_\_\_\_\_ %Body Fat (optional): \_\_\_\_\_

MEDICAL	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart – Auscultation Standing			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hyper-mobility, scoliosis)			

**MUSCULOSKELETAL**

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE** \_\_\_\_\_ \* Station-based examination only

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared 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.

Date of Examination: \_\_\_\_\_

**Stamp or Label:** \_\_\_\_\_

MD Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

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's assistant, chiropractor, or nurse practitioner. EXPLAIN 'YES' ANSWER (attach another sheet if necessary):

I certify that everything I have recorded in the above medical history is to the best of my ability known as true. I do not hold any entity responsible for any injuries associated with an invalid medical history.

Parent/Guardian Sign (required): \_\_\_\_\_ Student Sign (required): \_\_\_\_\_ Date: \_\_\_\_\_

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Personnel Use Only: Athletic Trainer or Intermediate Head Coach  
 Medical History Form was reviewed by Name \_\_\_\_\_ Date \_\_\_\_\_ Page 2 of 2