PREPARTICIPATION PHYSICAL EVALUATIO N -- MEDICAL HISTORY

This the, in 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

	Yes	No
1.	!	!
2.	!	!
	!	!
3.	!	!
	!	!
	!	!
	!	!
	!	!
	!	!
	!	!
	!	!

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	!	!
	Do you have asthma?	!	!
	Do you have seasonal allergies that require medical treatment?	!	!
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your D F W L W L W \ or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	!	!
15.	Have you ever had a sprain, strain, or swellirliswe55tha	!	!
		!	!
		!	!

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.

If, between this date and the beginning of D U W L F L S D W L R Q, any illness or injury should occur that may limit this student's participation, I agree to notify the school 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 responses could subject the student in question to penalties determined by the UIL

Student Signature: Parent/Guardian Signature: Date:

Any Yes answer to questions 1, 2, 3, 4, 5, 6 or 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. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE 3 (5) 2 5 0 $ 1 & (OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

This Medical History Form was reviewed by: Printed Name______________________ Date__________ Signature______________________

MEDICAL