

Austin Independent School District (AISD)
2025 - 2026 PARTICIPATION FORM

School _____

| | | | | | | | | |
|--------------------------------|------------|----------|------------|------------|---------------|------------|-------------------------------------|------------|
| Last Name | First Name | MI | Student ID | Grade | Date of Birth | Sex | Sports (List All Participating In) | |
| Street Address (No P.O. Boxes) | | | | City | | Zip | | Home Phone |
| Guardian's Name | | Employer | | Cell Phone | | Work Phone | Relationship to Student | |
| Guardian's Name | | Employer | | Cell Phone | | Work Phone | Relationship to Student | |

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

| | 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"/> | 12. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician? | <input type="checkbox"/> | <input type="checkbox"/> | Within the past year, have you experienced an asthma attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| What Age? _____ | | | Are you prescribed an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| What was the diagnosis? _____ | | | 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 passed out 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"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <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 had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check appropriate box and explain below. | | |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Upper <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot | | |
| Has any family member or relative died of heart problems or of sudden unexplained death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee | | |
| Has any family member 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)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/Calf | | |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you unsatisfied with your current weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a head injury or concussion? | <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 been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you have any other medical conditions not previously mentioned (for example, diabetes, thyroid disease, immune disorders, bleeding disorder, ADHD, mental health disorder, etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____ | | | <u>MALES ONLY</u> | | |
| When was the last concussion? _____ | | | 20. Are you missing a testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain below) | | | Do you have any testicular swelling or masses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | <u>FEMALES ONLY</u> | | |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 21. When was your first menstrual period? _____ | | |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| 5. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 6. Are you currently under a doctor's care for a specific illness, injury or medical condition? | <input type="checkbox"/> | <input type="checkbox"/> | What was the longest time between periods in the last year? _____ | | |
| 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills? | <input type="checkbox"/> | <input type="checkbox"/> | * I choose not to provide written information on Question 20-21 but will discuss with a medical professional: <input type="checkbox"/> | | |
| 8. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness form. I understand it is the responsibility of my family to schedule and pay for such ECG. | | |
| Do you have any allergies (for example, to medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | Explain Yes Answers (use another sheet if necessary) _____ | | |
| Is an epipen required? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 11. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

It is understood that even though protective equipment is worn by the athletes, whenever needed, the possibility of accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs. If, in the judgement 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 such account of such care and treatment of such student. If, between this date and the beginning of participation, 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: _____

| | |
|--|-------------------------------------|
| This Medical History Form was reviewed by: | |
| Doctor: _____ Signature | School Official: _____ Signature |

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ Pulse _____

| | | | |
|----|---|---|---|
| BP | / | / | / |
|----|---|---|---|

brachial blood pressure while sitting

% Body fat (optional) _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

| | 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) If indicated | | | |
| Skin | | | |
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |
| Marfan's stigmata (arachnodactyly, pectus, excavatum, joint hypermobility, scoliosis) | | | |

Austin ISD requires that each athlete have an annual physical dated after April 15, 2025

CLEARANCE

Cleared; Recommendations: _____

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____

Reason: _____

| | |
|---|---|
| <p>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.</p> | |
| Name (print/type) _____ | Date of Examination: _____ |
| Address: _____ | Phone: _____ |
| Signature: _____ | SIGNATURE ALSO REQUIRED BELOW MEDICAL HISTORY ON FRONT OF FORM |

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.