The McAllen ISD Athletic Department will be utilizing electronic forms for student athlete paperwork for the 2021-2022 school year. We would like to thank you for your cooperation. Utilizing online forms will expedite the student/athlete's paperwork as well as save valuable resources. Please log on to mcallenisd.rankonesport.com.

The required annual athletic physical and health history cannot be filled out online - the parent/guardian and physician must complete it. **If your child does not receive the free physical provided at a MISD campus,** you must print a physical and medical history by selecting the Forms for Download and Print tab at the top of the page or obtain a form from your campus Athletic Trainer or Athletic Coordinator. This is the pre-participation physical form approved by the UIL and MISD **(only this updated 2020 form may be used).** Once you have selected the tab you will see the link to the physical and medical history and will be able to download and print form. You are encouraged to fill out the medical history prior to printing the form.

YOU MAY BEGIN FILLING FORMS ONLINE BEGINNING April 28, 2021

1. The parent/guardian will be asked to provide information, such as phone numbers, email, name of the primary physician, and insurance policy information. **Please make sure you have this information available when filling out the forms electronically.**

2. To access the required athletic participation forms for McAllen ISD, hold your cursor over the "Electronic Participation Forms" tab. You will get a drop list of all required forms (UIL Form Signature Page and McAllen ISD Athletic Participation Form).

3. Remember that in order to submit online forms appropriately, you and your child must fill out and sign in all required spaces. Forms will **not** be accepted electronically without all required information being completed.

4. To begin, click on the form name and fill out the information requested. Please include your son's/daughter/'s full name as they are registered through MISD. Parent/Guardian must have their son/daughter present along with the student's ID number available to complete the forms. If you do not know the answer to a question, please answer the question with N/A or none.

5. To sign the document, click inside the signature box and hold your mouse down, this will allow you to create an "Electronic Signature." If you make a mistake and need to start over, click on the refresh icon next to the signature box. If you are using an IPAD, you may create an electronic signature by holding your finger to the screen and signing your name or by using a stylus.

6. Once you have filled out all of the information on each page, you will have the opportunity to print the document. **Please note that information cannot be "Saved as a Draft" – all forms must be completed in one session.**

7. You will receive a confirmation email from Rank One once your paperwork is submitted and complete.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

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

Student's Name: (print) _____ Sex _____ 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.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		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 activity 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 swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
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? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

☐ 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. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League 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 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.

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: _____

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

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

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

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

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

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	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 practice, before, during or after school, (both in-season and out-of-season) or performance/ games/matches.

McAllen Family Medicine Residency Clinic
An outpatient clinic of STHS McAllen

205 E. Toronto Ave.
McAllen, Texas 78503
Phone: (956) 687-6155
Fax: (956) 994-9820

SOUTH TEXAS HEALTH SYSTEM
McALLEN

STHS Pre-Participation Physical Evaluation

I, _____ (Parent/Guardian), hereby give my permission to South Texas Health System, to perform a pre-participation physical evaluation. It is understood by the undersigned that the results of this evaluation are for athletics/band participation only and should not substitute a routine physical evaluation with your family physician or medical provider. In accepting this pre-participation physical evaluation, the undersigned waives any and all claims against South Texas Health System, the McAllen Family Medicine Residency Clinic, resident physicians, physicians and all associated employees connected with any way, or arising out of the services rendered in connection therewith.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

It is understood that the results of the physical evaluation will be shared with appropriate personnel of the McAllen Independent School District to determine athletic/band eligibility. I hereby authorize use or disclosure of the named individual's pre-participation evaluation as described below to McAllen Independent School District.

SIGNED (PARENT/GUARDIAN) _____ DATE _____

STUDENT NAME (PRINTED) _____ LEGAL SEX _____DOB _____

ADDRESS _____ CITY _____ ZIP CODE _____

SCHOOL DISTRICT: McAllen Independent School District SCHOOL: _____

PARENT/GUARDIAN EMERGENCY CONTACT:

NAME _____ RELATION: _____

PHONE NUMBER: _____ CELL PHONE NUMBER: _____

McAllen Family Medicine Residency Clinic
An outpatient clinic of STHS McAllen

205 E. Toronto Ave.
McAllen, Texas 78503
Phone: (956) 687-6155
Fax: (956) 994-9820

Evaluación física previa a la participación de STHS

Yo, _____ (padre/ guardián), por este medio doy mi permiso para South Texas Health System, realizar una evaluación física previa a la participación atlestimo/banda. Se entiende por el suscrito que los resultados de esta evaluación son solo para atletismo/participación en la banda y no debe sustituir una evaluación física de rutina con su médico de cabecera o proveedor médico. En aceptar esta evaluación física previa a la participación, el firmante abajo renuncia a cualquier reclamo en contra South Texas Health System, McAllen Family Medicine Residency Clinic, médicos residentes, médicos y todos los empleados asociados, conectado de cualquier manera o que surjan de los servicios prestados en relación con los mismos.

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN DE SALUD PROTEGIDA
Se entiende que los resultados de la evaluación física, se compartirán con el personal apropiado del Distrito Escolar Independiente de McAllen para determinar la elegibilidad atlética/banda. Por lo presente autorizo el uso o divulgación de la persona nombrada para la evaluación previa a la participación como se describe abajo para Distrito Escolar Independiente de McAllen.

FIRMA (Padre/Guardián) _____FECHA _____

NOMBRE DE ESTUDIANTE _____SEXO LEGAL _____ FECHA DE NACIMIENTO _____

DIRECCIÓN _____CIUDAD _____ CÓDIGO POSTAL _____

DISTRITO ESCOLAR: McAllen Independent School District ESCUELA: _____

PADRE/GUARDIAN CONTACTO DE EMERGENCIA:

NOMBRE _____ RELACIÓN:_____

NÚMERO DE TELÉFONO: _____ NÚMERO CELULAR: _____