PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or 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.

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.** ***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 medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	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 sports 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 the 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?	☐	☐
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 sport 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

		Yes	No
16.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
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? _____

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 assistant, chiropractor, or nurse practitioner.

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

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, 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 athletic competition, 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 FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE 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 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 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 games/matches.

STUDENT ATHLETE EMERGENCY and INSURANCE INFORMATION

Student Name: _____ Date of Birth: ____/____/____

Parent/Legal Guardian Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address: _____
Street City Zip Code

Secondary Emergency Contact Person (Someone other than the above parent/guardian):

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

The following information is very important to have on file in case of emergency situations. Please fill in the information to the best of your abilities. Please list any insurance coverage, including Champus, Medicare, Medicaid, accident policies, HMO's, etc. If you do not have insurance coverage, please write "No Insurance" in the space for the insurance company.

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____
Street

_____
City State Zip Code

NAME OF INSURED: _____
Last First M.I.

RELATIONSHIP: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Revised 03/2013

STUDENT ATHLETE CONSENT FOR TREATMENT AND CARE

I, _____, parent or guardian of _____ recognize that as a result of athletic participation, medical treatment on an emergency or non-emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for such medical care. I do hereby authorize in advance to such emergency and non-emergency care, including hospital care, as may be deemed necessary under the then existing circumstances. The purpose of this release is to authorize the school to obtain, through a physician of its choice, any medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

Additionally, I give my permission and consent for the evaluation and treatment of my child by the physicians at the Trinity Mother Frances Health System, including TMFHS's Saturday Sports Injury Clinic.

I hereby consent to and permit Trinity Clinic Physicians/Staff (and/or their designee) to provide evaluation, medical treatment (including emergent or urgent treatment if necessary) to me/my child, including hospitalization and physician follow-up according to their medical judgment at the Trinity Mother Frances Health System and/or its Saturday Morning Sports Injury Clinic.

I further authorize Trinity Mother Frances Health System to obtain and release personal medical/insurance data about me for treatment payment or operations related to my injury, illness, physical examination(s) in accordance with the applicable state and federal privacy laws.

I am of sound mind and competent to sign this form.

I have read this form, understand it and agree to the terms and conditions.

_____ _____

Parent/Legal Guardian signature Date

_____ _____

Student/Athlete (if 18 years of age or older) Date

OTC Consent Form

Athlete _____ Grade _____

Sport(s) _____

Over the Counter Drug Consent:

I hereby give permission to the athletic trainer(s) representing the Quitman Independent School District to, using his/her judgment, administer over the counter medications to my son/daughter named above for simple medical problems including but not limited to: General inflammation from injury and musculoskeletal soreness, headache, indigestion, stomach ache, diarrhea, muscle cramps, simple allergic reactions, & sinus congestion.

I agree _____ (Parent/Guardian initials)

I disagree _____ (Parent/Guardian initials)

Please list any medications your son/daughter may be allergic to:

_____ _____

_____ _____

_____ _____

Please list anything that your son/daughter is allergic to (food, insects, etc.):

_____ _____

_____ _____

_____ _____

Parent/Guardian Printed: _____

Parent/Guardian Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RULES

Attention School Authorities: This form must be signed yearly by both the student and parent/guardian and be on file at your school before the student may participate in any practice session, scrimmage, or contest. A copy of the student's medical history and physical examination form signed by a physician or medical history form signed by a parent must also be on file at your school.

Student's Name_____ Date of Birth_____

Current School _____

Parent or Guardian's Permit

I hereby give my consent for the above student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.

The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.

If, in the judgement of any representatives of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

Your signature below gives authorization that is necessary for the school district, its trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

To the Parent:	☐	Baseball	☐	Football	☐	Softball	☐	Tennis	☐ Wrestling
Check any activity in which this	☐	Basketball	☐	Golf	☐	Swimming & Diving	☐	Track & Field	
student is allowed to participate.	☐	Cross Country	☐	Soccer	☐	Team Tennis	☐	Volleyball	

Date _____

Signature of parent or guardian _____

Street address _____

City/State/Zip _____

Home area code and telephone _____

Business telephone_____

The student's signature is required on the reverse side of this form.

GENERAL INFORMATION

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball, or volleyball camps (exception: school coaches may hold one 6-day camp in their school district for incoming 7th, 8th and 9th grade students),
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, football, soccer, softball, or volleyball.
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

GENERAL ELIGIBILITY RULES

According to UIL standards, students are eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See 504 handicapped exception.)
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time day students in a participant high school.
- initially enrolled in the ninth grade not more than four calendar years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the *Constitution and Contest Rules).*
- have observed all provisions of the Awards Rule.
- have not represented a college in a contest.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, Basketball, Football, Soccer, Softball, and Volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not allow their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.
- **I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.**

I have read the regulations cited above and agree to follow the rules.

Date _____ Signature of student _____

ACKNOWLEDGEMENT FORM

I am aware that playing/participating in high school athletics can be a dangerous activity involving MANY, MANY RISKS OF INJURY.

I understand that the dangers and risks of playing or practicing to play/participate in high school athletics include, but are not limited to, death, serious neck and spinal injuries that may result in partial or complete paralysis, partial or complete brain damage, serious injury (temporary or permanent) to virtually all bones, joints, ligaments, muscles, tendons, and other parts or aspects of my body, my general overall health and well being.

I understand that the dangers and risks of playing or practicing to play/participate in high school athletics may result not only in serious injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and to generally enjoy my life. I also understand that it is essential for my well being that I not participate or practice to play/participate in high school athletics unless I am in generally good health and physical condition.

I also completely understand that the Trinity Mother Frances Health System and Trinity Clinic physicians ("Trinity Physicians") who are conducting the Preparticipation Physical Screening ARE NOT PERFORMING A COMPLETE PHYSICAL EXAMINATION OR EVALUATION ON ME. Additionally, I understand that it is my responsibility to truthfully and completely respond the attached medical history questionnaire.

With this in mind, I have correctly, truthfully and completely answered all of the questions in the Medical History Questionnaire. I have truthfully and completely advised the Trinity Physicians of my medical and family history and have told them of any limitations on my activities based on medical reasons.

I am of sound mind and competent to sign this form.

I have read this Acknowledgment Form and understand it.

Date: _____

_____ _____

Signature of Student Printed Name

_____ _____

Signature of Parent/Guardian Printed Name

Revised 02/2004

SUDDEN CARDIAC ARREST AWARENESS FORM

Revised June 2013

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.

What is the treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- **CALL 911**
- **Begin CPR**
- **Use an Automated External Defibrillator (AED)**

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The UIL *Pre-Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find information on additional screening?

- American Heart Association (www.heart.org)
- AugustHeart (www.augustheart.org)
- Championship Hearts Foundation (www.championshipheartsfoundation.org)
- Cypress ECG Project (www.cypressecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (Print)

_____ _____

Student Signature Date

_____

Student Name (Print)

CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student _____

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.
- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:
A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:
(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;
(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and
(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:
(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
(C) have signed a consent form indicating that the person signing:
(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
(iv) understands the immunity provisions under Section 38.159.

_____ _____
Parent or Guardian Signature *Date*

_____ _____
Student Signature *Date*

University Interscholastic League

Parent and Student Agreement/Acknowledgement Form
Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- 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.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at www.uil.utexas.edu. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

Waiver and Release of Liability Form

Printed Name of Student _____ Date _____

Printed Name of Parent/Guardian _____ Date _____

The parent or guardian of every participant in the UIL student screening process must read and sign this waiver form prior to participation.

I am the parent or guardian of the minor listed above (or I am the Student listed above). I understand and agree that this physical screening meets the UIL minimum requirements for a student athlete to participate in school athletic competition.

I agree and understand that Trinity Mother Frances Health System, and its affiliates, including but not limited to, Mother Frances Hospital Regional Health Care Center, and Trinity Clinic and all physicians, directors, corporate member, religious sponsors, officers, employees, and agents (collectively hereinafter referred to as "Trinity Mother Frances") conducting screening SHALL NOT ASSUME ANY RESPONSIBILITY or LIABILITY in case my child is (or MY children are or I am) injured during any school athletic practice or competition. Furthermore, I specifically agree and understand that there may be severe risks (including death) associated with my child's (children's/my) participation in school athletics and related activities. I expressly agree and understand that these physical screenings DO NOT TAKE THE PLACE OF a comprehensive physical examination which is available to my child (children/me). I KNOWINGLY, WILLINGLY, AND VOLUNTARILY ACCEPT THE RISKS OF HAVING MY CHILD (CHILDREN) UNDERGO (OR IN MY UNDERGOING) only the UIL minimum screening requirements.

Additionally, I agree and understand that Trinity Mother Frances and all physicians who are performing the physical screenings SHALL NOT BE HELD LIABLE BY ME (OR US) for any claims, demands, suits and/or expenses arising out of or related to the physical screening performed on my child (children/me) to the fullest extent permitted by law.

I (we) hereby acknowledge that the health care practitioner is administering this pre-participation evaluation or medical screening without compensation and without expectation of compensation and further acknowledge the limitations on recovery of damages from the health care practitioner in connection with the pre-participation physical examination or medical screening being performed.

I (we) hereby KNOWINGLY AND FREELY RELEASE AND WAIVE ANY AND ALL CLAIMS, OF ANY NATURE WHATSOEVER, against Trinity Mother Frances as a result of any injury or illness arising out of or relating (in any way) to the screening and/or my child (children's/my) participation in school athletic practice and/or competition.

_____ _____

Parent/Guardian signature Student's signature (age 18 or above)

STUDENT ATHLETE PRIVACY FORM
Authorization for
Disclosure of Protected Health Information

I, _____, parent or guardian of _____ (the "student athlete"), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel represent Trinity Mother Frances Health System's Sports Medicine to release information regarding the student athlete's protected health information and related information regarding any injury or illness during the student athlete's training for and participation in athletics at _____ School (the "School"). This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of the School.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete's protected health information is a condition for the student athlete's participation in interscholastic sports at the School. I understand that the student athlete's protected health information is protected under federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the School's athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

_____ _____

Print Student Athlete Name Signature of Parent/Legal Guardian

_____

Date

NOTICE OF PRIVACY PRACTICES

By signing above I acknowledge that I have received or have been offered a copy of Trinity Mother Frances Health System's Notice of Privacy Practices.