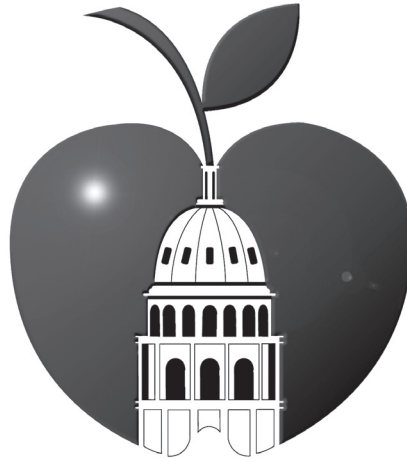


Corrected  
2/24/15

Grade \_\_\_\_\_

Student Name \_\_\_\_\_



# 2015 – 2016 PRE-PARTICIPATION PHYSICAL PACKET



# Austin Independent School District

## Athletic Training Services



### Sports Physical Resource List

The **BEST** place to get a sports physical and an annual physical exam is with your child's physician. Annual exams are very important to identify current medical concerns AND prevent future problems. Please see the following list of clinics that will give pre-participation physicals for students who do not have their own family physician.

Please take the AISD forms with you so your child's physician can review the front page and complete the physical exam. **The AISD Pre-Participation Physical Packet is REQUIRED. NO OTHER FORMS WILL BE ACCEPTED.** All clinics require that the packet be completed prior to the appointment; including parent/guardian signatures. Please pick one up at your school or go on-line to [www.austinisd.org/athletics/forms](http://www.austinisd.org/athletics/forms).

| <b>PRIMARY CARE CLINICS – Must Call for Appointment</b> |  |                |                 |
|---|--|----------------|-----------------|
|   | <b>Address</b>   | <b>Phone #</b> | <b>Price \$</b> |
| <b>Carousel</b>   | www.carouselhealth.com   | 512-744-6000   |                 |
| <b>Children's Health Express</b>                        | www.dellchildrens.net/services_and_programs/childrens_health_express | 512-324-0060   | \$15            |
| <b>CommUnity Care Services</b>                          | www.communitycaretx.org  | 512-978-9015   |                 |
| <b>Lone Star Circle of Care</b>                         | 1221 Ben White 78704   | 1-877-800-5722 |                 |
|   | 11111 Research Blvd (adjacent to Seton Northwest in Health Plaza)    |                |                 |
| <b>People's Community Clinic</b>                        | 2909 N IH 35   | 512-478-4939   |                 |
| <b>Seton Community Health Centers</b>                   | 2811 E 2 <sup>nd</sup>   | 512-324-4930   |                 |
|   | 3706 S 1 <sup>st</sup>   | 512-324-4940   |                 |
|   | 8913 Collinfield   | 512-324-6850   |                 |
| <b>Texas Sports and Family Medicine</b>                 | 3200 Red River St.   | 512-473-0201   |                 |
| <b>Victory Medical and Family Care</b>                  | 4303 Victory Drive   | 512-462-3627   | \$50            |
| <b>Austin Regional Clinic</b>                           | www.austinregionalclinic.com   | 512-272-4636   |                 |

| <b>URGENT CARE CLINICS – Walk-In Only</b> |                                  |                |                 |
|---|----------------------------------|----------------|-----------------|
|   | <b>Address</b>                   | <b>Phone #</b> | <b>Price \$</b> |
| <b>Nextcare</b>                           | 6001 W William Cannon Suite 302  | 512-288-3627   | \$25            |
| <b>Austin Immediate Care</b>              | 5000 W Slaughter Lane            | 512-282-2273   | \$60            |
| <b>MedSpring Urgent Care</b>              | 11521 N Ranch Rd 620 Suite 100   | 512-402-6830   | \$39            |
|   | 3906 N. Lamar Suite 100          | 512-861-8040   |                 |
|   | 208 W Ben White                  | 512-861-8060   |                 |
|   | 2120 Guadalupe Suite 100         | 512-861-8030   |                 |
| <b>Concentra Urgent Care</b>              | 10001 N IH 35 Frontage #300      | 512-440-0555   | \$35            |
|   | 4301 W William Cannon Dr #320    | 512-467-6608   |                 |
|   | 9333 Research Blvd #400          | 512-467-7232   |                 |
| <b>Pro-Med Medical Care Centers</b>       | 2000 W Anderson Lane             | 512-459-4367   | \$39            |
|   | 3801 S Lamar                     | 512-447-9661   |                 |
|   | 13831 N Hwy 183                  | 512-250-0424   |                 |
| <b>Care Spot Express</b>                  | 401 W Slaughter Lane Suite 300   | 512-686-4227   | \$45            |
|   | 500 W Canyon Ridge Dr Suite J350 | 512-253-4931   |                 |
| <b>Texan Urgent Care</b>                  | 1920 Riverside Blvd Suite A-110  | 512-326-1600   | \$50            |
|   | 3607 Manor Rd Suite 100          | 512-928-4600   |                 |
| <b>RediClinic (Inside HEB)</b>            | 6900 Brodie Lane                 | 512-892-2300   | \$59            |
|   | 500 Canyon Ridge Drive           | 512-836-9000   |                 |
| <b>Minute Clinic (Inside CVS)</b>         | 2610 Lake Austin Blvd            | 866-389-2727   | \$59            |
|   | 5526 S Congress Ave              |                |                 |
|   | 3500 W Slaughter Lane            |                |                 |
|   | 11300 N Lamar Blvd               |                |                 |



## Austin Independent School District

Interscholastic Athletics  
3200 Jones Road Austin, Texas 78745  
(512) 414-1050 Fax (512) 414-0469

Dear Parent or Guardian:

A yearly physical exam is required in order for your child to participate in AISD Athletics. This physical must be dated after April 15<sup>th</sup> and will be valid for one school year.

Attached you will find a physical exam form that must be completed by you and your doctor. This completed form is to be returned to the coach prior to participation in athletics for the 2015-2016 school year.

If your child has a doctor, it is very important for your child to visit his/her own doctor for this examination, because the doctor knows your child and their medical history. This is especially important if your child has any prior medical conditions or is under a doctor's care for any medical conditions including asthma. If your child does not have a doctor, you should first find a doctor and then make an appointment with this doctor's office or clinic. **It is best to have this appointment between May 1, 2015 and August 1, 2015.**

For children without a primary care physician or the ability to obtain a sports physical, there is another option. A group of doctors and nurses have volunteered to perform sports physicals in large sessions in April and May of 2015. Middle school physicals will be **April 23<sup>rd</sup> and April 28<sup>th</sup>** and high school physicals will be **May 12<sup>th</sup> and May 13<sup>th</sup>**. This physical is a station based exam with physicians in each specialty available. Your athlete's school will be assigned to a specific site and date after all forms have been returned. AISD will provide bus transportation to the physical site from each participating school. Please make plans to pick up your athlete at the assigned site to answer any questions the physicians may have. If you are unable to pick up your athlete, AISD will provide bus transportation to their home. The physicals are offered by AISD Athletics in conjunction with Dell Children's Medical Center and Travis County Medical Society.

If your child is going to participate in this years physicals, we need the following:

- Completed physical packet, including parent and student signatures, athlete contact information, and medical history
- Completed project access form
- All forms returned to the athletic coordinator by the date specified

On the day of the physical:

- Wear comfortable clothes, including shorts and a t-shirt
- Bring glasses or wear contacts if necessary
- Do not exercise immediately before attending the physical
- Bring something to eat and drink as you may be at the location past dinner

If you have any questions regarding the physicals, please contact Denise Vanlandingham at the athletic office at 414-1042.

## Physical and Participation Requirements

Physicals are required yearly to participate in athletics in AISD. Physicals must be dated after April 15th to be valid for the following school year. A physical will be good for one school year, regardless of the date of the examination. Free physicals are provided by AISD Athletics in May. Contact your coach for more information on these physicals. Any change in medical status or visit to a medical provider during the year will require written clearance from the treating physician before return to normal activity.

## U.I.L. 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.

## UIL Parent Information Manual

Austin ISD Athletics is required to provide you access to the UIL Parent Information Manual. This manual can be found on the UIL website under athletics. The web address is [www.uil.texas.org](http://www.uil.texas.org). A hard copy of this manual may be requested from the athletic office. You must read and agree with this entire document.

## Parent (Guardian) Permit

- I hereby give my consent for the above student to compete in the University Interscholastic League approved sports and travel with the coach or other representatives of the school on any trips.
- It is understood that even though the athlete wears protective equipment whenever needed, the possibility of an accident resulting in injury still remains. Neither the U.I.L. nor the school district assumes any responsibility in case an accident occurs.
- I have read and understand the U.I.L. rules listed in this document and agree that my son/daughter will abide by all of the U.I.L. rules.
- I also agree to be responsible for the safe return of all athletic equipment issued by the school and will pay for any and all lost, stolen or damaged equipment issued to my son/daughter.
- If, in the judgment of any representative 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. Your signature below gives authorization that is necessary for the school district, its athletic trainers, nurses, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment of your student.
- I understand that failure to provide accurate and truthful information could subject the student in question to penalties as determined by the UIL.
- I have been provided the UIL Parent Information Manual regarding health and safety issues and my responsibilities as a parent/guardian.
- I hereby agree that my answers to the questions on the Medical History Form are complete and correct to the best of my knowledge. If between this date and the beginning of the athletic participation or anytime during the school year, any illness or injury should occur that may limit this student's participation, I agree to notify by written doctor's orders the school authorities of such illness or injury.

### 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 instructions or schedule any practice for an individual or 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 fund, fees or transportation for non-school activities.



**This form must be signed and returned for your child to participate in the physicals.**

**No one is being paid for the health care your child receives.** The care provided to your child is being given by Project Access volunteers without expectation of payment or compensation and is given to and received by your child in exchange for limitations on recovery for damages from the volunteer.

By signing below, you confirm that you understand and agree to the above conditions.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Student's Name (Please Print): \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Student's School: \_\_\_\_\_

-----  
**Favor de firmar esta forma y regresar con su hijo(a) para que pueda participar en los exámenes físicos.**

**Nadie es pagado por el cuidado médico, que sus hijos reciben.** El cuidado proporcionado a sus hijos está siendo donado por los voluntarios del Proyecto Acceso sin la expectativa de pago o de remuneración y es dado y recibido por sus hijos en el intercambio de las limitaciones en la recuperación para los daños del voluntario.

Firmando abajo, usted confirma que entiende y acepta las condiciones antedichas.

Firma de Padres/Tutores Legales: \_\_\_\_\_

Fecha: \_\_\_\_\_

Nombre del estudiante (letra de molde): \_\_\_\_\_

Fecha de nacimiento del estudiante: \_\_\_\_\_

La escuela del estudiante: \_\_\_\_\_



# CONCUSSION ACKNOWLEDGEMENT FORM

**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 38.15

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Signature of Athlete \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_

Date \_\_\_\_\_

# AUSTIN ISD RETURN TO PLAY PROTOCOL

Once an athlete is cleared by a physician, the following progression will be followed. An athlete may not begin this progression until they are symptom free for 24 hours. If at any time symptoms return, the progression is stopped and restarted once the symptoms are resolved.

Day 1: 10 Minutes on Bike or Light Jogging

Day 2: 20 minutes of Running

Day 3: Non-Contact Practice with Team

Day 4: Full Practice

Day 5: Participation in Full Contact Game

Austin ISD is currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a computer program to successfully evaluate and manage concussions. If an athlete is believed to have suffered a head injury during competition, it is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is done on a computer and takes about 20 minutes to complete. Essentially, it is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test. This program poses no risks to your student-athlete.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to your family doctor or another local physician to help evaluate the injury. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

The Austin ISD administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. We will be offering this testing to athletes involved in certain contact sports. Even though we highly recommend this testing, it is not required in order for participation in athletics.

**I hereby grant my consent to the registration of my child on [axonsports.com](http://axonsports.com) and/or [impacttest.com](http://impacttest.com) and to the administration and supervision of the concussion assessment by Austin ISD and hereby accept the terms of use and privacy policy of both.**

Signature of Athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_





## SUDDEN CARDIAC ARREST AWARENESS FORM

Name of Student: \_\_\_\_\_ Grade \_\_\_\_\_

### What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

### What causes Sudden Cardiac Arrest?

- **Conditions present at birth**
  - *Inherited (passed on from parents/relatives) conditions of the heart muscle:*
    - ◆ **Hypertrophic Cardiomyopathy** – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
    - ◆ **Arrhythmogenic Right Ventricular Cardiomyopathy** – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
    - ◆ **Marfan Syndrome** – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.
  - *Inherited conditions of the electrical system:*
    - ◆ **Long QT Syndrome** – abnormality in the ion channels (electrical system) of the heart.
    - ◆ **Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome** – other types of electrical abnormalities that are rare but run in families.
  - *NonInherited (not passed on from the family, but still present at birth) conditions:*
    - ◆ **Coronary Artery Abnormalities** – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
    - ◆ **Aortic valve abnormalities** – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
    - ◆ **Non-compaction Cardiomyopathy** – a condition where the heart muscle does not develop normally.
    - ◆ **Wolff-Parkinson-White Syndrome** – an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.
- **Conditions not present at birth but acquired later in life:**
  - ◆ **Commotio Cordis** – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
  - ◆ **Myocarditis** – infection/inflammation of the heart, usually caused by a virus.
  - ◆ **Recreational/Performance/Enhancing drug use.**
- **Idiopathic:** Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

### 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 14 important cardiac elements.
- The UIL Pre-Participation Physical Evaluation – Medical History form includes ALL 14 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?**

- The cardiac section on the UIL Health and Safety website (UIL.texas.org)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name (Print)

**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.
- I understand and agree that the results of any 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.texas.edu](http://www.uil.texas.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 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.

**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.

**Name (Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship** \_\_\_\_\_

Name \_\_\_\_\_

**PLEASE PRINT**

Austin Independent School District  
**EMERGENCY STUDENT INFORMATION CARD**

**Sport(s)**

Austin ISD policy requires the completion of this permit for participation in athletics.

1. \_\_\_\_\_

If, in the judgment of any representative 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 district and any school representative from any claim by any person whatsoever on account of such care and treatment of said student.

2. \_\_\_\_\_

3. \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (*Last, First*) \_\_\_\_\_ Grade \_\_\_\_\_ Student ID # \_\_\_\_\_

School Attending \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian(s) Name \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_

Name \_\_\_\_\_

**PLEASE PRINT**

Austin Independent School District  
**EMERGENCY STUDENT INFORMATION CARD**

**Sport(s)**

Austin ISD policy requires the completion of this permit for participation in athletics.

1. \_\_\_\_\_

If, in the judgment of any representative 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 district and any school representative from any claim by any person whatsoever on account of such care and treatment of said student.

2. \_\_\_\_\_

3. \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (*Last, First*) \_\_\_\_\_ Grade \_\_\_\_\_ Student ID # \_\_\_\_\_

School Attending \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian(s) Name \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Parent's Insurance Co. \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_



## AUSTIN ISD ATHLETICS ACCIDENT INSURANCE

Austin ISD provides a supplemental accident insurance policy for all middle school and high school UIL participants while participating in a UIL sanctioned activity before, during, or after school and while traveling to that activity. This supplemental insurance policy requires your primary insurance to be used first. After your primary insurance has reached its policy limitations, parents may file a claim for the reimbursement of medical bills up to the supplemental insurance plan limitations. If you do not have personal insurance, the plan may be used to cover medical bills up to the plan limitations only. Neither Austin ISD nor the insurance provider will pay 100% of the cost incurred from an injury.

If you do not have personal insurance for your son/daughter, please consider purchasing extended coverage for them. Austin ISD offers student insurance policies to students and parents at the beginning of each school year.

A claim form must be submitted along with your primary insurance's Explanation of Benefits statements and itemized bills from the provider. This claim form must be filed within 6 months of the injury. Section A will be completed by a school official. Section B is to be completed by the parent/guardian.

After benefits have been approved, the company will issue a check for the allowable amount to either the provider or the parent/guardian if the bill has already been paid. You can direct all claim status questions to 1-800-328-2739.

## CONSENT TO OBTAIN/RELEASE HEALTH INFORMATION

I understand and agree that, in order to provide a coordinated system of care, the Athletic Department and School Health Team may exchange health care information about the Student with the Student's physician or other healthcare providers. I consent to allow Athletic Department medical personnel to contact the student's physician directly to share information or request records pertinent to athletic participation. I understand and agree that medical personnel may share the Student's health care information with AISD personnel, in accordance with AISD protocol, in order to provide appropriate attention to the Student's health care needs. I give permission to release and share all necessary health information. I understand that this information will automatically be shared in emergency situations as necessary.

Student Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Austin Independent School District (AISD) 2015 – 2016  
**ATHLETIC DEPARTMENT ATHLETIC 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 |
| Female Guardian's Name   |            | Employer |            | Cell Phone |               | Work Phone | Relationship to Student             |            |
| Male Guardian's Name   |            | Employer |            | Cell Phone |               | Work Phone | Relationship to Student             |            |
| Secondary Emergency Contact Name   |            |          |            | Cell Phone |               | Home Phone | Relationship to Student             |            |
| Do you have private insurance, medicaid and/or CHIP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type or Company. _____ |            |          |            |            |               |            |                                     |            |

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

|   | <b>YES</b>               | <b>NO</b>                |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year?<br>Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician?<br>What Age? _____<br>What was the diagnosis? _____<br>Have you ever passed out during or after exercise?<br>Have you ever had chest pain during or after exercise?<br>Do you get tired more quickly than your friends do during exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Have you had high blood pressure or high cholesterol?<br>Have you ever been told you have a heart murmur?<br>Has any family member or relative died of heart problems or of sudden unexpected death before age 50?<br>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)?<br>Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?<br>Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a head injury or concussion?<br>Have you ever been knocked out, become unconscious, or lost your memory?<br>If yes, how many times? _____<br>When was the last concussion? _____<br>How severe was each one? (Explain below) _____<br>Have you ever had a seizure?<br>Do you have frequent or severe headaches?<br>Have you ever had numbness or tingling in your arms, hands, legs, or feet?<br>Have you ever had a stinger, burner, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever gotten unexpectedly short of breath with exercise?<br>Have you ever been diagnosed with asthma?<br>Within the past year, have you experienced an asthma attack?<br>Are you prescribed an inhaler?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you missing any paired organs?   | <input type="checkbox"/> | <input type="checkbox"/> | 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"/> |
| 6. Are you currently under a doctor's care for a specific illness, injury or medical condition?   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had a sprain, strain, or swelling after injury?<br>Have you broken or fractured any bones or dislocated any joints?<br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?<br>If yes, check appropriate box and explain below.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot<br><input type="checkbox"/> Neck <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee<br><input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/Calf<br><input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?<br>Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you unsatisfied with your current weight?<br>Do you lose weight regularly to meet weight requirements for your sport?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you feel stressed out?   | <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"/> |
|   |                          |                          | 19. Do you have any other medical conditions not previously mentioned (for example, diabetes, thyroid disease, immune disorders, bleeding disorder, etc)?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | <b><u>FEMALES ONLY</u></b>  |                          |                          |
|   |                          |                          | 20. When was your first menstrual period? _____<br>When was your most recent menstrual period? _____<br>How much time do you usually have from the start of one period to the start of another? _____<br>How many periods have you had in the last year? _____<br>What was the longest time between periods in the last year? _____   |                          |                          |
|   |                          |                          | <b>Explain Yes Answers</b> in the box below ( <i>use another sheet if necessary</i> ) _____<br>_____<br>_____   |                          |                          |

**CIRCLE ALL SPORTS THE STUDENT IS ALLOWED TO PARTICIPATE IN:**

Football    Volleyball    Baseball    Wrestling    Basketball    Golf    Soccer    Softball    Tennis    Cross Country    Track & Field    Swimming & Diving

**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. Our signatures indicate we have read, understand, and agree with the entire document including the Medical History, Steroid Agreement, UIL Rules, UIL Parent Information Manual, Concussion Information, Insurance Information, and Parent Permit.**

**Student Signature:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|  |  |
|--|--|
| <b>This Medical History Form was reviewed by:</b><br><br>Doctor: _____<br><div style="text-align: right; margin-right: 50px;"><i>Signature</i></div> | School Official: _____<br><div style="text-align: right; margin-right: 50px;"><i>Signature</i></div> |
|--|--|

**PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

*brachial blood pressure while sitting*

BMI % \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_

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

|   | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---|--------|-------------------|-----------|
| <b>MEDICAL</b>  |        |                   |           |
| 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  |        |                   |           |
| <b>MUSCULOSKELETAL</b>  |        |                   |           |
| 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, 2015**

**CLEARANCE**

Cleared; Recommendations: \_\_\_\_\_

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

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

*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: \_\_\_\_\_

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 games/matches.

