

PAID:



PASADENA ISD UIL PRE-PARTICIPATION EVALUATION FORM GRADES 7-12

2026-2027

RECEIPT#

It is preferred that this original form be used with the correct school year. **NO PHYSICAL CONDUCTED OUTSIDE OF PISD WILL BE ACCEPTED PRIOR TO APRIL 1ST.** It is the parent/student responsibility to update new information as soon as it becomes available. (New address, phone number, etc.)

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER AND ALL ONLINE UIL FORMS AT www.rankone.com MUST BE COMPLETED BEFORE A STUDENT CAN PARTICIPATE IN **ANY ATHLETIC/MARCHING BAND ACTIVITY**, WHICH INCLUDES TRY-OUTS, OFFSEASON, PRACTICE, PERFORMANCE OR COMPETITION (BEFORE, DURING OR AFTER SCHOOL). ALL HIGH SCHOOL FORMS SHOULD BE GIVEN TO AN ****ATHLETIC TRAINER ONLY****. INTERMEDIATE ATHLETIC FORMS SHOULD BE TURNED INTO THE CAMPUS ATHLETIC COORDINATOR.

Student ID #: _____ Sex: _____ Date of Birth: ____/____/____ Age: _____ Grade (2026-2027): _____
Last Name: _____ First Name: _____ Home Phone: _____ Cell Number: _____
Address: _____ City/Zip: _____

Circle school for 2026-2027: **CTHS Dobie Memorial Pasadena Rayburn South Houston**
Beverly Hills Bondy Jackson Miller Park View Queens San Jacinto Southmore South Houston Thompson
Please circle one:
Athletics/Fine Arts/Both

*****Pasadena ISD requires an annual physical exam. This exam expires July 31, 2027*****

Height: _____ Weight: _____ Pulse: _____ BP: _____
Vision: R - 20/_____ L - 20/_____ Pupils: Equal/Unequal Corrected: Y N

MEDICAL EXAMINER SECTION

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*	CLEARANCE
Appearance				<input type="checkbox"/> Cleared <input type="checkbox"/> Cleared after completing evaluation/ rehabilitation for: _____ <input type="checkbox"/> Not cleared for: _____ Recommendations: _____ ***IF NOT INITIALLY CLEARED, NOTE OF CLEARANCE MUST BE ON LETTERHEAD OF CLEARING PHYSICIAN*** <i>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.</i>
Eyes/Ears				
Nose/Throat				
Lymph Nodes				
Heart – Auscultation Supine				
Heart – Auscultation Standing				
Heart – Lower Extremity Pulses				
Pulses				
Lungs				
Abdomen				
Genitalia (males only)				
Skin				
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)				
MUSCULOSKELETAL				Date of Examination: _____ Name (print/type): _____ Address: _____ Phone Number: _____ Examiner's Signature: _____ Please Include Clinic Stamp or Clinic Note from Date of Service to Validate Exam
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

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

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade (2026-2027) _____ School (2026-2027) _____ Student ID# _____
 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		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			18. Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____			Females Only I choose not to provide written information on Question 19 but will discuss with a medical professional <input type="checkbox"/>		
How severe was each one? (Explain below)			19. When was your first menstrual period? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	Males Only I choose not to provide written information on Question 20 but will discuss with a medical professional <input type="checkbox"/>		
6. Are you under a doctor's care for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	20. Are you missing a testicle? _____		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any testicular swelling or masses? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary): _____ _____ _____		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

It is understood that even though protective equipment is worn by the student, 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. I also authorize any physician to release confidential information concerning a student injury to the athletic trainer involved.

If, between this date and the beginning of any UIL activity, 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. Your signature gives authorization which is necessary for the district, athletic trainer, coaches, and student insurance personnel to share information concerning medical diagnosis and treatment. This is to conform with Federal guidelines, ie. HIPAA and FERPA		
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 & REQUIRED ONLINE FORMS MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY TRYOUT, PRACTICE, PERFORMANCE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

For School Use Only:

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