



Physicals



The time has come to get ready for the new school year. Magnolia I.S.D. policy states that **every student athlete, cheerleader, drill team member, student manager, student athletic trainer, high school band member and ROTC cadet must have a physical every year.** Junior high band members are also recommended to get a physical.

The physicians from Texas Orthopaedic and Sports Medicine and Affinity Medical Associates will be performing the athletic physicals for Magnolia ISD on **Wednesday May 22nd** at the **Magnolia High School Gymnasium**. Physicals will start immediately after school and run until the last individual has completed their physical.

All pre-participation paperwork is available online. You will need to go to **arbiterathlete.com** (see back for instructions) and complete the electronic participation forms and **print the medical history and physical form. Attach \$20.00 cash** to the form and send it with them that day.

Coaches from Bear Branch Jr. High and Bear Branch 6th Grade will bus all students getting a physical to Magnolia High School for the physical. Parents are encouraged to pick their child up from the Magnolia High School gym after the physical.

Again, we hope you take advantage of this offer. If you have any questions please feel free to contact us at Magnolia High School (281) 356-3572, ext 7066 or dkeyes@magnoliaisd.org

Sincerely,

Danielle Keyes A.T.C., L.A.T.
Isaac Diaz L.A.T.

Physicals

Wednesday May 22nd

MHS Gym

\$20 CASH

1. To create an account for online Pre-Participation
 - I. Go to: <https://www.arbiterathlete.com>
 - II. You will need to create a parent account and a student account
2. After both parent and student accounts have been created be sure to “link” them together.
3. Select ALL of the sports that you may be interested in participating in during the upcoming school year.
4. **BOTH** parent and student must complete the following forms
 - I. The following forms need to be completed and printed to bring on the day of the physical for the physician to complete
 - i. UIL- Pre Participation Medical History
 - ii. UIL- Pre Participation Physical Examination
 - II. The followings forms only need to be completed and signed digitally
 - i. Athlete/ Parent Concussion Statement
 - ii. UIL Sudden Cardiac Arrest
 - iii. UIL Acknowledgment of Rules
 - iv. UIL Parent and Student Agreement/Acknowledgement
 - v. MISD Emergency Contact Information
 - vi. MISD Policies
 - vii. OTC Consent (HS students only)
5. If you have any questions please contact us
 - I. Danielle Keyes- dkeyes@magnoliaisd.org
 - II. [MHS Training Room- 281-356-3572 X7066](tel:281-356-3572)

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.

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.

- | | 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"/> |
| 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? _____ | | | <i>Female Only</i> | | |
| 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"/> | <i>Male Only</i> | | |
| 6. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you have two testicles? _____ | | |
| 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"/> | 21. 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"/> | | | |
| 9. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, 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"/> | | | |

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: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. **THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

For School Use Only:

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