

**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 activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 ID# \_\_\_\_\_ Grade Entering ('24-'25) \_\_\_\_\_ School \_\_\_\_\_ Sport \_\_\_\_\_  
 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.

	<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 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? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician? Have you ever passed out during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden unexplained death before age 50? 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? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in activities for any heart problems?	<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 activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times? _____ When was your last concussion? _____ How severe was each one? (Explain below)	<input type="checkbox"/>	<input type="checkbox"/>	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:	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you missing any paired organs?	<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"/>
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Females Only</i> I choose not to provide written information on Question 19 but will discuss with a medical professional: 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? _____		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Males Only</i> I choose not to provide written information on Question 20 but will discuss with a medical professional: 20. Are you missing a testicle? _____ Do you have any testicular swelling or masses? _____		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	An electrocardiogram (ECG) is not required. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):		
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 athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL**

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

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

**For School Use Only:**

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

**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
brachial blood pressure while sitting

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

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

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

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

Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.

# ‘24 – ‘25 ELECTROCARDIOGRAM SCREEN (ECG) CONSENT FORM AND RELEASE OF LIABILITY

An ECG screen (sometimes also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screen may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

As per HB 76 of the 86<sup>th</sup> Texas Legislature a parent can elect to have their child receive an ECG. Cypress Fairbanks currently has an ECG program and will provide a free ECG the first year a student elects to receive one. Any sequential ECG’s will be at the expense of the parents or guardian of the student and done outside of the school. We also ask that if you do an ECG out of the school district, that you share any abnormal results with the school district to ensure the safe participation in athletics of your child.

By signing below, I am either electing or declining an ECG screen provided by the Cypress-Fairbanks Independent School District for my child. By electing to receive an ECG screen, I acknowledge the limitations of an ECG screen and that sudden cardiac death may still occur, despite this screening. I further acknowledge that students with an abnormal ECG screen will be required to perform further testing (i.e., an echo or ultrasound) and/or a medical consultation prior to being released to resume participation for CFISD activities, at the parent’s expense. By my signature below, I hereby release and forever discharge, and waive, any and all claims against the Cypress-Fairbanks Independent School District, its employees, trustees, consultants and contractors that relate to the student’s election regarding and/or participation in the ECG screening project, and authorize medical personnel to review the ECG results, and interpret and use the same for diagnostic and aggregated statistical purposes in addition to other medical documentation on file in with the school district, and in accordance with the Family Educational Privacy Rights Act and the Health Insurance Portability and Accountability Act of 1996.

I DO hereby consent to participation in the ECG screen on behalf or that of my minor child.

I DECLINE participation in the ECG screen on behalf or that of my minor child.

\_\_\_\_\_  
Child’s Name Printed

\_\_\_\_\_  
Date

**X**

\_\_\_\_\_  
Parent/Guardian Name Printed

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

PARENTE-MAIL ADDRESS \_\_\_\_\_

### INFORMATION

STUDENT ID #: \_\_\_\_\_ NAME \_\_\_\_\_

AGE: \_\_\_\_\_ GENDER: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

GRADE: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

CIRCLE HIGH SCHOOL ATTENDING 2024-2025:

Cy-Creek	Cy-Fair	Cy-Falls	Cy-Lakes	Cy-Park	Cy-Ranch
Cy-Ridge	Cy-Springs	Cy-Woods	Jersey Village	Langham Creek	Bridgeland

*This section to be completed by Athletic Trainer  
DATE ECG COMPLETED*

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



# Cypress-Fairbanks Independent School District

## Parent Permission for School-Sponsored Activity

with District transportation     without District transportation

_____	_____	_____
Student Name	Campus	Grade
_____	(____)____-_____	(____)____-_____
Parent/Guardian	Primary Phone	Secondary Phone
_____	(____)____-_____	(____)____-_____
Secondary Emergency Contact	Primary Phone	Secondary Phone

ACTIVITY: \_\_\_\_\_

**PARENT ACKNOWLEDGMENT:** In order for your student to participate in this school-sponsored activity, written parent permission is required below. Student safety is a high priority; however, under state law the school district is not responsible for medical or other costs associated with a student injury, unless the injury results from a school employee’s negligent operation of a District vehicle. By completing and returning this form, you are authorizing your student to participate in the school-sponsored activity described above and acknowledge that you are responsible for any medical or other costs associated with a student injury that may occur during the activity, except as stated above. Students are required to use District-provided transportation if it is provided as indicated above (unless the campus principal or designee has specifically authorized a student to arrive or depart separately and the parent/guardian has completed any additionally required written permissions). The District shall not be liable or responsible for any action, injuries or damages that occur to students riding in vehicles that are not provided by the District.

If the above student needs immediate care and treatment as a result of injury or illness, I authorize CFISD employees to deliver or consent to care.

**PRESCRIPTION MEDICATION ADMINISTRATION:** Prescription medications administered by the school nurse during a regular school day will be transported/administered by the field trip sponsor for an activity limited to regular school hours.

\_\_\_\_\_/\_\_\_\_/20\_\_\_\_  
Parent/Legal Guardian Signature      Date

**Complete this section ONLY if your child requires the administration of a prescription medication** during an activity **extending beyond the regular school day**, please list the medication(s) you authorize CFISD staff members to administer in the table below. The field trip sponsor will provide instructions for parents/guardians to drop-off required medication(s) before the event. In accordance with CFISD Board policy FFAC (LOCAL), medication must be supplied in the original container (labeled for the student), and students may not transport medications to or from school or a school-sponsored event.

Medication Name	Dose	Route	Time

\_\_\_\_\_/\_\_\_\_/20\_\_\_\_  
Parent/Legal Guardian Signature      Date



## Fine Arts Field Trip High School

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

\_\_\_\_\_  
Campus

\_\_\_\_\_  
Grade

Please provide a copy of the student's current insurance card.

\_\_\_\_\_  
Name of Insurance Company

\_\_\_\_\_  
Identification Number

\_\_\_\_\_  
Group Number

In case of a student emergency, CFISD employees should be knowledgeable of your child's medical conditions to provide safe care. Please list any medical conditions or regular medications below.

Asthma       Diabetes       Seizure Disorder       List Severe Food Allergies \_\_\_\_\_

Daily and Emergency Medications: \_\_\_\_\_

Other Information: \_\_\_\_\_

### District Provided Non-prescription Medication Permission

Authorization is hereby given for the administration of the following district provided non-prescription medications to my child by designated school employees. Circle Yes or No in last column.

Symptom	Medication	Brand Name	Circle Yes or No
Allergic Reaction	Diphenhydramine	Benadryl	Yes or No
Mild Pain/Fever	Ibuprofen	Addaprin, Motrin	Yes or No
Mild Pain/Fever	Acetaminophen	Tylenol	Yes or No
Mild Abdominal Pain Heartburn, Nausea	Calcium Carbonate Chews	Tums, Maalox	Yes or No

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

\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_

### Medication Log (For CFISD Use Only)

Date: (Month/Day)	Time	Signs & Symptoms	Medication Dispensed	Initials
/				
/				
/				
/				
/				
/				

**PARENT/STUDENT UIL MARCHING BAND  
ACKNOWLEDGEMENT FORM**

*Updated 2018*

No student may be required to attend a marching band related practice for more than eight hours outside the academic school day per calendar week (Sunday through Saturday). This provision applies to students in all components of the marching band. **Exception:** For schools that begin instruction prior to the fourth Monday in August the limit of eight hours of rehearsal outside of the academic school day per calendar week shall begin on the Tuesday immediately following Labor Day. Schools under this exception shall be limited to eight hours of rehearsal outside of the academic day per school week (12:01 AM on the first day of school of the calendar week through the end of the school day on the last day of instruction of the school week) until the Tuesday immediately following Labor Day.

On performance days (football games, competitions and other public performances) bands may hold up to one additional hour of warm-up and practice beyond the scheduled warm-up time. Multiple performances on the same day do not allow for additional practice and/or warm-up time.

Examples of Activities Subject to the UIL Marching Band Eight Hour Rule.

- Marching Band Rehearsal (Both Full Band and Components)
- Any Marching Band Group Instructional Activity
- Breaks
- Announcements
- Debriefing and Viewing Marching Band Videos
- Passing Off Marching Band Music
- Marching Band Sectionals (Both Director and Student Led)
- Clinics for The Marching Band or Any of its Components

The Following Activities Are Not Included in the Eight Hour Time Allotment:

- Travel Time to and From Rehearsals and/or Performances
- Rehearsal Set-Up Time
- Pep Rallies, Parades and Other Public Performances
- Instruction and Practice For Music Activities Other Than Marching Band And Its Components

NOTE: More information about Marching Band practice limitations can be found at:  
[www.uiltexas.org/music/marching-band](http://www.uiltexas.org/music/marching-band)

“We have read and understand the Eight-Hour Rule for Marching Band as stated above and agree to abide by these regulations.”

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

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

This form is to be kept on file by the local school district.

**COST OF PHYSICAL: \$20.00 CASH ONLY OR MONEY ORDER ONLY**

<b>CAMPUS</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>	<b>8TH GRADE FEEDERS</b>
<b>CY SPRINGS HOPPER</b>	Friday, April 5, 2024	11:00am-3:00pm	<b>CY SPRINGS MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS ANTHONY, HOPPER, KAHLA</b>
<b>CY LAKES THORNTON</b>	Thursday, April 18, 2024	1:30pm-5:00pm	<b>CY LAKES MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>JERSEY VILLAGE COOK/DEAN</b>	Thursday, April 18, 2024	2:00PM-6:00PM	<b>JERSEY VILLAGE LARGE COMMONS</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY RANCH SMITH</b>	Tuesday, April 30, 2024	1:00pm-4:30pm	<b>CY RANCH MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY RIDGE</b>	Wednesday, May 1, 2024	1:30pm-5:30pm	<b>CY RIDGE MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>BRIDGELAND SPRAGUE</b>	Wednesday, May 1, 2024	1:00pm-5:00pm	<b>BRIDGELAND MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>WOODS SPILLANE</b>	Saturday, May 4, 2024	12:30pm-2:00pm	<b>WOODS MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY CREEK BLEYL</b>	Monday, May 6, 2024	2:00pm-6:00pm	<b>CY CREEK MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY PARK ROWE</b>	Wednesday, May 8, 2024	1:00pm-5:00pm	<b>CY PARK MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY FAIR ARNOLD</b>	Thursday, May 9, 2024	2:30pm-6:30om	<b>CY FAIR MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>LANGHAM CREEK ARAGON</b>	Wednesday, May 15, 2024	2:00pm-6:00pm	<b>LANGHAM CREEK MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>
<b>CY FALLS LABAY</b>	Wednesday, May 22, 2024	11:30PM-4:30PM	<b>CY FALLS MAIN GYM</b>	<b>CURRENT 8<sup>TH</sup>-GRADE FEEDERS</b>