

GCCISD will not accept physicals or completed paperwork dated prior to April 15, 2026

Student's Name _____

26-27 School _____

Student ID _____

26-27 Grade _____

Date of Birth _____

Gender _____

STUDENT-PARENT/GUARDIAN SECTION

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. 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. **Explain "Yes" answers on the notes page provided on page 2.** Circle questions you don't know the answers to. Any "yes" answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation, which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games, or matches.

Explain all "yes" answers on the back of this page.

MEDICAL HISTORY

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
 2. Have you been hospitalized overnight in the past year? Yes No
Have you ever had surgery? Yes No
 3. Have you ever had prior testing for the heart ordered by a physician? Yes No
Have you ever passed out during or after exercise? Yes No
Have you ever had chest pain during or after exercise? Yes No
Do you get tired more quickly than your friends do during exercise? Yes No
Have you ever had racing of your heart or skipped heartbeats? Yes No
Have you had high blood pressure or high cholesterol? Yes No
Have you ever been told you have a heart murmur? Yes No
Has any family member or relative died of heart problems or of sudden, unexpected death before age 50? Yes No
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? Yes No
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes No
Do you have any lingering effects from a COVID diagnosis? Yes No
Has a physician ever denied or restricted your participation in activities for any heart problems? Yes No
 4. Have you ever had a head injury or concussion? Yes No
Have you ever been knocked out, become unconscious, or lost your memory? Yes No
If yes, how many times? _____ When was your last concussion? _____
How severe was each one? (Explain on the back of this page) _____
Have you ever had a seizure? Yes No
Do you have frequent or severe headaches? Yes No
Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No
Have you ever had a stinger, burner, or pinched nerve? Yes No
 5. Are you missing any paired organs? Yes No
 6. Are you currently under a doctor's care for a specific medical issue? Yes No
 7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? Yes No
 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Yes No
Does this allergy require an EpiPen? Yes No
 9. Have you ever been dizzy during or after exercise? Yes No
 10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes No
 11. Have you ever become ill from exercising in the heat? Yes No
 12. Have you had any problems with your eyes or vision? Yes No
 13. Have you ever gotten unexpectedly short of breath with exercise? Yes No
Do you have asthma? Yes No
Do you have seasonal allergies that require medical treatment? Yes No
 14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activities or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes No
 15. Have you ever had a sprain, strain, or swelling after injury? Yes No
Have you broken or fractured any bones or dislocated any joints? Yes No
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No
If yes, check appropriate box and explain on the back.

Head	Elbow	Hip	Neck	Forearm	Thigh
Back	Wrist	Knee	Chest	Hand	Shin/Calf
Shoulder	Finger	Ankle	Upper Arm	Foot	
 16. Do you want to weigh more or less than you do now? Yes No
 17. Do you feel stressed out? Yes No
 18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? Yes No
- Females Only** 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? _____
- Males Only** I choose not to provide written information on question 20 and 21 but will discuss with a medical professional
20. Are you missing a testicle? _____
21. Do you have testicular swelling or masses? _____

Explain all "yes" answers on the back of this page.

An electrocardiogram (ECG) is *not required*. I have read and understood 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.

MEDICALEXAMINER SECTION

Height: _____ Weight: _____ Pulse: _____

BP (brachial blood pressure while sitting): _____ / _____ (_____ / _____ : _____ / _____)

Vision: R - 20/ _____ L - 20/ _____ Corrected: Y N

Pupils: Equal/Unequal

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart-Auscultation			
Supine Position			
Heart-Auscultation			
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			

CLEARANCE

* Station-based examination only

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.**

Date of Examination: _____

Name (print/type): _____

Address: _____

Phone Number: _____

Physician's Signature: _____

This form, in its entirety, must be on file before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches or performances/competitions.

Parent Signature

Printed name: _____ Signature: _____

School Use Only

Date: _____

Printed name: _____

Signature: _____

