

## TAPPS MEDICAL HISTORY FORM

This Medical History Form must be completed annually by the parent (or guardian) and student in order for the student to participate in TAPPS athletic and selected fine art activities. These questions are designed to assist the practitioner in determining if the student has developed any condition which would make it hazardous to participate in an extracurricular activity.

**STUDENT NAME:** \_\_\_\_\_ **GRADE LEVEL:**      9    10    11    12  
**GENDER:** Male / Female      **AGE:** \_\_\_\_\_ **DATE OF BIRTH:**    \_\_\_/\_\_\_/\_\_\_\_\_  
**HOME ADDRESS:** \_\_\_\_\_ **CONTACT PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
**PERSONAL PHYSICIAN:** \_\_\_\_\_ **PHYSICIAN PHONE #:** (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

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If the answer to any question is yes, please discuss the circumstances with your provider at the time of the physical examination.

	<b>YES</b>	<b>NO</b>	<b>UNKNOWN</b>
Have you had a medical illness or injury since your last physical?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had prior testing ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your racing of your heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your heart skip beats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any member of your biological family died of heart problems or sudden unexplained death prior to the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has any biological family member been diagnosed with an 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"/>
Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	YES	NO	UNKNOWN
Has a physician ever denied or restricted your participation in extracurricular activities for any heart related problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a diagnosed head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious or lost memories?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to the question above, how many times? _____			
If yes, when was your last diagnosed concussion? ___/___/_____			
If Yes, how severe were each of the concussions? Discuss with the Provider			
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been unexpectedly short of breath while exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed by a physician with asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seasonal allergies which require medical attention or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under a doctor's care for any condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or nonprescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently using an inhaler, prescribed or nonprescribed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known allergies (pollen, medicine, food or insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have current skin problems (examples: itching, rashes, acne, warts, blisters or fungus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to weigh more or less than you do today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with or treated by a physician for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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YES NO UNKNOWN

Do you use any special protective or corrective equipment that are not usually used for your particular activities (examples: knee brace, neck roll, foot orthotics, retainer, prescription goggles or hearing aid)?

Have you ever had swelling after a sprain, strain or injury?

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YES NO UNKNOWN

Have you ever 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, please check each box below that applies.

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"/>		

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**Female Students Only** (If left blank I agree to provide such information to the provider at the time of examination)

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? \_\_\_\_\_ days

What was the longest time between periods in the last year? \_\_\_\_\_ days

How many periods have you had in the last year?

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**Male Students Only** (If left blank I agree to provide such information to the provider at the time of examination)

Are you missing a testicle? YES NO

Do you have any testicular pain? YES NO

Do you have any testicular swelling or masses? YES NO

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## TAPPS MEDICAL HISTORY FORM

It is understood that even though protective equipment is worn by the student participant, whenever needed and as prescribed, the possibility of accident or injury still remains. Neither the Texas Association of Private and Parochial Schools (TAPPS) nor the TAPPS member school assumes any responsibility should injury occur.

If in the judgement of any representative of the school the student should need immediate care and / or treatment as a result of any injury or illness, 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 or designated school representative. I do hereby indemnify and save harmless the TAPPS member school, TAPPS, treating medical establishment and representatives of each from any claim by any on account of such care and treatment of said student.

If, between the date affixed to this document and the beginning of extracurricular training, competition, or performance any injury or illness should occur that may limit the student's participation, I agree to promptly notify the recognized and designated authority at the member school of such injury or illness.

I hereby state that to the best of my knowledge, my answers to the questions asked on this form are complete and correct. I understand that failure to provide truthful and complete responses could subject the student to nonparticipation at the member school and penalties as determined by TAPPS.

Student Full Name: \_\_\_\_\_

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

Date of Signature: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_

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

Date of Signature: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_