

U.I.L. Athletic Participation Form  
*Burleson Independent School District*

Grade for 20\_\_ -20\_\_ year: 7 8 9 10 11 12 School: \_\_\_\_\_ Sports: \_\_\_\_\_

**BACKGROUND INFORMATION**

Athlete's Full Name \_\_\_\_\_ Gender: M F Birthday \_\_\_\_\_ Age \_\_\_\_\_  
Athlete's School ID \_\_\_\_\_ Home Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Father's Name \_\_\_\_\_ Cell Phone# \_\_\_\_\_  
Father's Employer's Company/Name \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Cell Phone# \_\_\_\_\_  
Mother's Employer's Company/Name \_\_\_\_\_ Work Phone# \_\_\_\_\_

**EMERGENCY INFORMATION**

Other Person to call in case of Emergency if Parents cannot be reached:  
Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone # \_\_\_\_\_  
Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Physician \_\_\_\_\_ Family Physician Phone # \_\_\_\_\_  
Allergies to medicine or other (please list) \_\_\_\_\_  
Any medicine taking regularly (please list) \_\_\_\_\_  
Any medical concerns that should be noted \_\_\_\_\_

**INSURANCE INFORMATION**

Name Insurance is listed under \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Policy # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone # \_\_\_\_\_

**\*\*Secondary insurance is not provided by BISD, but can be purchased through BISD. If interested, please contact the head athletic trainer for more details.\*\***

**PARTICIPANT NOTIFICATION**

If, between this date and the beginning of athletic competition or once participating in competition, any illness or injury should occur that might limit this student's participation, I agree to notify the Licensed Athletic Trainers at Burleson ISD of such illness or injury.

**RELEASE TO RETURN TO PLAY AFTER MEDICAL CONSULTATION**

Athletes who seek medical attention from a healthcare provider cannot return to athletic participation without the following two criteria:

1. a signed/dated release from a Medical Physician on file with the Burleson ISD Athletic Trainers, AND
2. release by the Burleson ISD Licensed Athletic Trainers

**\* Note: Parental Authorization and/or Notification WILL NOT be accepted\***

**GENERAL INFORMATION**

School coaches may not:

- Transport, register, or instruct students in grades 7-12 from their attendance zone in non-school baseball, basketball, football, soccer, softball or volleyball camps (exception: See Section 1209 of the Constitution and Contest Rules),
- Give any instruction or schedule any practice for an individual or a team during the off-season except during the one in school day athletic period in baseball, basketball, football, soccer, softball, or volleyball.
- Schools and school booster clubs may not provide funds, fees, or transportation for non-school activities.

**PARENT OR GUARDIAN PERMIT**

- I hereby give my consent for the above named student to compete in University Interscholastic League approved sports, and travel with the coach or other representative of the school on any trips.
- 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 high school assumes any responsibility in case an accident occurs.
- I have read and understand the University Interscholastic League rules on the reverse side of this form and agree that my son/daughter will abide by all of the University Interscholastic League rules.
- The undersigned agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student.
- If, in the judgment of any representatives of the school, the above named student needs 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 to said student by any physician, licensed athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.
- Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

## GENERAL ELIGIBILITY RULES

According to UIL standards, students are eligible to represent their school in interscholastic activities if they:

- are not 19 years of age or older on or before September 1 of the current scholastic year. (See Section 446 of the Constitution and Contest Rules for exception).
- have not graduated from high school.
- are enrolled by the sixth class day of the current school year or have been in attendance for fifteen calendar days immediately preceding a varsity contest.
- are full-time day students in a participant high school they wish to represent.
- initially enrolled in the ninth grade not more than four years ago.
- are meeting academic standards required by state law.
- live with their parents inside the school district attendance zone their first year of attendance. (Parent residence applies to varsity athletic eligibility only.) When the parents do not reside inside the district attendance zone the student could be eligible if: the student has been in continuous attendance for at least one calendar year and has not enrolled at another school; no inducement is given to the student to attend the school (for example: students or their parents must pay their room and board when they do not live with a relative; students driving back into the district should pay their own transportation costs); and it is not a violation of local school or TEA policies for the student to continue attending the school. Students placed by the Texas Youth Commission are covered under Custodial Residence (see Section 442 of the *Constitution and Contest Rules*).
- have observed all provisions of the Awards Rule.
- have not represented a college in a contest.
- have not been recruited. (Does not apply to college recruiting as permitted by rule.)
- have not violated any provision of the summer camp rule. Incoming 10-12 grade students shall not attend a baseball, basketball, football, soccer, or volleyball camp in which a seventh through twelfth grade coach from their school district attendance zone, works with, instructs, transports or registers that student in the camp. Students who will be in grades 7, 8, and 9 may attend one baseball, one basketball, one football, one soccer, one softball, and one volleyball camp in which a coach from their school district attendance zone is employed, for no more than six consecutive days each summer in each type of sports camp. Baseball, basketball, football, soccer, softball, and volleyball camps where school personnel work with their own students may be held in May, after the last day of school, June, July, and August prior to the second Monday in August. If such camps are sponsored by school district personnel, they must be held within the boundaries of the school district and the superintendent or his designee shall approve the schedule of fees.
- have observed all provisions of the Athletic Amateur Rule. Students may not accept money or other valuable consideration (tangible or intangible property or service including anything that is usable, wearable, salable or consumable) for participating in any athletic sport during any part of the year. Athletes shall not receive valuable consideration for allowing their names to be used for the promotion of any product, plan or service. Students who inadvertently violate the amateur rule by accepting valuable consideration may regain athletic eligibility by returning the valuable consideration. If individuals return the valuable consideration within 30 days after they are informed of the rule violation, they regain their athletic eligibility when they return it. If they fail to return it within 30 days, they remain ineligible for one year from when they accepted it. During the period of time from when students receive valuable consideration until they return it, they are ineligible for varsity athletic competition in the sport in which the violation occurred. Minimum penalty for participating in a contest while ineligible is forfeiture of the contest.
- did not change schools for athletic purposes.
- <http://www.uiltexas.org/files/athletics/manuals/parent-information-manual.pdf> I have been provided the UIL Parent Information Manual regarding health & safety issues including concussions and my responsibilities as a parent/guardian. I understand that failure to provide accurate and truthful information on UIL forms could subject the student in question to penalties determined by the UIL.

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

## MEDICATION PERMIT

Licensed Athletic Trainers designated by the Burleson Independent School District board policy are hereby given my consent to administer non-prescription medication to said student. Further consent is hereby given to administer prescription medication to said student when prescribed by the team physician and/or student's personal physician. Parent Signature \_\_\_\_\_

## PARENT OR GUARDIAN PERMIT

I have completed the background, emergency, and insurance information. I have also completed the drug and steroid forms as well as the medical history report in this form and affirm that it is correct. I have read and understand the U.I.L rules on this form and agree that my son/daughter will abide by all of them.

The above named student is now under my control and in my custody. I hereby give my consent for the above named student to compete in the University Interscholastic League of Burleson I.S.D. approved sports and to go with the coach or school representative, or any parent, on any field trips or games. **THE PARENTS HEREWITH GRANT PERMISSION FOR SCHOOL EMPLOYEES TO SECURE MEDICAL SERVICES FOR THE ABOVE NAMED STUDENT 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 U.I.L. nor the B.I.S.D. assumes any responsibility in case an accident occurs. In consideration of the above named student being permitted to make such trips and take part in such activities, I hereby release the University Interscholastic League and the Burleson I.S.D., its Trustees, Superintendent, Principals, Teachers, and Employees, together with all persons, trips and activities (excluding paid certified carriers), from any and all liability and responsibility in connection with such trips and activities and hereby release all said parties from all liability by reason of any accident, injuries, or losses suffered by said student while on said trip or activities, including travel, and I agree to indemnify and hold said parties harmless from all claims hereafter made or assured by or on behalf of the above named student and his parents, heirs, executors, or assigns.

The undersigned hereby agrees to be responsible for the safe return of all athletic equipment issued by the school to the above named student. I also authorize any physician to release confidential information concerning an athletic injury to the Athletic Trainer involved.

DATE \_\_\_\_\_ PARENT SIGNATURE \_\_\_\_\_

Subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

NOTARY PUBLIC \_\_\_\_\_



# University Interscholastic League



## Parent and Student Agreement/Acknowledgement Form Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

### STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in UIL athletic activities, I agree that I will not use anabolic steroids as defined in the UIL Anabolic Steroid Testing Program Protocol. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at [www.uil.utexas.org](http://www.uil.utexas.org). I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by UIL.

Student Name (Print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

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

### PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in UIL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school as specified in the UIL Anabolic Steroid Testing Program Protocol which is available on the UIL website at [www.uil.utexas.org](http://www.uil.utexas.org). I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by UIL.

Name (Print): \_\_\_\_\_

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

Relationship to student: \_\_\_\_\_

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED Jan. 2011

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. *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*

|   |   |                                    |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
|---|---|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|--|-------------------------------|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year?<br/>Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever passed out during or after exercise?<br/>Have you ever had chest pain during or after exercise?<br/>Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Has any family member or relative died of heart problems or of sudden unexpected death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         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"/> Yes <input type="checkbox"/> No<br/>         Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, how many times? _____ When was the last concussion? _____</p> <p>How severe was each one? (Explain below) _____<br/>         Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, check appropriate box and explain below.</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females Only</i></p> <p>19. When was your first menstrual period? _____<br/>         When was your most recent menstrual period? _____<br/>         How much time do you usually have from the start of one period to the start of another? _____<br/>         How many periods have you had in the last year? _____<br/>         What was the longest time between periods in the last year? _____</p> | <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"/> 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      |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |

**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: \_\_\_\_\_

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 \_\_\_\_\_

**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* |
|--|--------|-------------------|-----------|
| <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)   |        |                   |           |
| Skin   |        |                   |           |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) |        |                   |           |
| <b>MUSCULOSKELETAL</b>   |        |                   |           |
| 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.

## BURLESON ISD DRUG TESTING AUTHORIZATION

Student's Full Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Student's ID Number \_\_\_\_\_ Student's Birthday \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

I, undersigned student, have been made aware that Burleson ISD's Drug Testing Policy is located on BISD's webpage under Policy FNF (LOCAL). I recognize and understand that I will be asked to provide urine samples for drug testing and agree to pay fifteen dollars for the initial drug test. I consent to any and all such testing conducted as part of the Burleson ISD Drug-Testing Policy FNF (LOCAL), and I understand that I may be asked to provide a urine sample for drug testing more than one time during a school year. I agree that I will not refuse to take any such test or otherwise dispute Burleson ISD's right to conduct any such test (s) on me. I have been given the right to ask questions about the Burleson ISD's Drug-Testing Policy FNF (LOCAL), and I fully understand and consent to its provisions. If I have attained the age of eighteen (18), I hereby give consent pursuant to the Family Education Rights and Privacy Act, for release of all the records and information identified in the Burleson ISD Drug-Testing Policy FNF (LOCAL) to the Head Coach, the Athletic Director, Principal, Sponsor, and Superintendent of the District. This consent to release and disclose such information is given and pursuant to all state and federal privacy statutes, including the Federal Education Rights and Privacy Act and the Hatch Amendment and is a waiver of any right of non-disclosure of such test records and results to the extent authorized in the program. If I have attained the age of eighteen (18), I give permission to the doctor(s) who have prescribed medication for the treatment of my medical condition(s) to verify the circumstance and discuss any effects that the medication(s) may have on my drug test results or school performance.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

I/We acknowledge that I/we have been made aware that Burleson ISD's Drug Testing Policy is located on BISD's webpage under Policy FNF (LOCAL). I/We recognize and understand that my son/daughter will be asked to provide urine samples for drug testing and that there is a charge of fifteen dollars for the initial drug test. I/We consent to any such testing conducted as part of Burleson ISD Drug-Testing Policy FNF (LOCAL), and I/We understand that my/our son/daughter may be asked to provide a urine sample for drug testing more than once in a school year. I/We agree not to dispute Burleson ISD's right to conduct any such test(s) on my/our son/daughter. I/We have been given the right to ask questions about the Burleson ISD Drug-Testing Policy FNF (LOCAL), and I/We fully understand its provisions. I/We hereby give consent, pursuant to the Family Education Rights and Privacy Act, for release of all of the records and information identified in the Burleson ISD Drug-Testing Policy FNF (LOCAL) to my/our son/daughter, to the Head Coach, the Athletic Director, Principal, Sponsor, and the Superintendent of the District. This consent to release and disclose such information is given pursuant to all the state and federal privacy statutes, including the Federal Education Rights and Privacy Act and the Health Amendment and is a waiver of any right of non-disclosure of such test records and results to the extent authorized in the program.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please fill out the back if your son/daughter is on any medication!!!!!!!!!!!!

Listed below are the prescription drugs and dosages my/our son/daughter takes on a permanent basis. I/We understand that, depending on the type of medications and the circumstance, its use may have to be verified and discussed with the doctor who prescribed it. I/We give permission to the doctor(s) who have prescribed medication for the treatment of my/our son/daughter's medical condition(s) to verify the circumstances and discuss any effects that the medication(s) may have on my/our son/daughter's drug test results or school performance.

Drug Name \_\_\_\_\_ Dosage \_\_\_\_\_

Drug Name \_\_\_\_\_ Dosage \_\_\_\_\_

Drug Name \_\_\_\_\_ Dosage \_\_\_\_\_

Drug Name \_\_\_\_\_ Dosage \_\_\_\_\_

Drug Name \_\_\_\_\_ Dosage \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

***NOTE: This document will be valid during this student's UIL participation.***