PAID:

PASADENA ISD
UIL PRE-PARTICIPATION EVALUATION FORM
GRADES 7-12

2026-2027

RECEIPT#

It is preferred that this original form be used with the correct school year. **NO PHYSICAL CONDUCTED OUTSIDE OF PISD WILL BE ACCEPTED PRIOR TO APRIL 1ST.** It is the parent/student responsibility to update new information as soon as it becomes available. (New address, phone number, etc.)

A COMPLETED PHYSICAL MUST BE ON FILE WITH THE ATHLETIC TRAINER AND ALL ONLINE UIL FORMS AT **www.rankone.com** MUST BE COMPLETED BEFORE A STUDENT CAN PARTICIPATE IN **ANY ATHLETIC/MARCHING BAND ACTIVITY,** WHICH INCLUDES TRY-OUTS, OFFSEASON, PRACTICE, PERFORMANCE OR COMPETITION (BEFORE, DURING OR AFTER SCHOOL). ALL HIGH SCHOOL FORMS SHOULD BE GIVEN TO AN ****ATHLETIC TRAINER ONLY****. INTERMEDIATE ATHLETIC FORMS SHOULD BE TURNED INTO THE CAMPUS ATHLETIC COORDINATOR.

Student ID #:_____ Sex: _____ Date of Birth:_____/_____/_____ Age:_____ Grade (2026-2027):_____

Last Name:_____ First Name:_____ Home Phone:_____ Cell Number: _____

Address:_____ City/Zip: _____

Circle school for 2026-2027: **CTHS** **Dobie** **Memorial** **Pasadena** **Rayburn** **South Houston**

Beverly Hills Bondy Jackson Miller Park View Queens San Jacinto Southmore South Houston Thompson

Please circle one:
Athletics/Fine Arts/Both

******Pasadena ISD requires an annual physical exam. This exam expires July 31, 2027******

Height:_____ **Weight**:_____ **Pulse** :_____ **BP**:_____

Vision: R – 20/_____ L – 20/_____ Pupils: Equal/Unequal Corrected: Y N

MEDICAL EXAMINER SECTION

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
Heart – Auscultation Supine			
Heart – Auscultation Standing			
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

❑ Cleared

❑ Cleared after completing evaluation/ rehabilitation for:_____

_____

❑ Not cleared

for:_____

_____

Recommendations:_____

_____

*****IF NOT INITIALLY CLEARED, NOTE OF CLEARANCE MUST BE ON LETTERHEAD OF CLEARING PHYSICIAN*****

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: _____

Examiner's Signature: _____

Please Include Clinic Stamp or Clinic Note from Date of Service to Validate Exam

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2026

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic/marching band activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic/marching band event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade **(2026-2027)** _____ School **(2026-2027)** _____ Student ID# _____

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
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
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 unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (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 sports for any heart problems?	☐	☐
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)		
	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?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care for a medical condition?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
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)?	☐	☐
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:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

		Yes	No
16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

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 but will discuss with a medical professional* ☐

20. Are you missing a testicle? _____
Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by the student, 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. I also authorize any physician to release confidential information concerning a student injury to the athletic trainer involved.

If, between this date and the beginning of any UIL activity, 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. Your signature gives authorization which is necessary for the district, athletic trainer, coaches, and student insurance personnel to share information concerning medical diagnosis and treatment. This is to conform with Federal guidelines, ie. HIPAA and FERPA

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 & REQUIRED ONLINE FORMS MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY TRYOUT, PRACTICE, PERFORMANCE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

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