



A PROUD TRADITION | A BRIGHT FUTURE

The Lamar CISD Athletic Department would like to thank you for taking the time to complete the UIL and Lamar CISD required forms to participate in the athletic program. All student athletes 7th -12th grade(s) are required to fill out and submit these forms online prior to each school year.

Lamar CISD and the UIL require the parent/legal guardian and student to complete the participation forms annually. Parents and students are required to read and submit the UIL forms as they pertain to them. This year's paperwork will be completed online to make the process convenient for all families. The link to the online paperwork is: <https://lamarcisd.rankonesport.com>

The only required form that cannot be done electronically is the annual physical and medical history. Parents will be able to print a physical and medical history during the electronic session. The student is required to use the Preparticipation Physical Examination Form provided. **NO OTHER** Physical Examination Form will be accepted as per the UIL. **A new physical exam must be given prior to each school calendar year.** Any physical administered prior to May 1, may not be valid after August 1.

All **online forms** must be completed in their **entirety** and the physical exam form must be returned to the athletic trainer or athlete's head coach before a student participates in **any** try-out, practice, athletic class, open gym, open weight room, athletic competition, or travels with an athletic team for any purpose.

Physical Dates – Spring 2019

Foster High School – May 2nd, 11:30 A.M. – 5:00 PM

Lamar Cons. High School – May 3rd, 8:00 A.M. – 3:00 P.M.

George Ranch School – May 10th, 8:00 A.M. – 4:00 P.M.

Terry High School – May 21st, 11:00 A.M. – 3:00 P.M.

Churchill Fulshear High School – May 22nd, 2:30 P.M. – 5:30 P.M.

Foster H.S. / Briscoe Jr. High

Tiffany Kizziah – Head AT

Chandra Teague – Asst. AT

832-223-3970

George Ranch H.S. / Reading Jr. High

Lance Hale – Head AT

Shelby Jacobs – Asst. AT

832-223-4361

Lamar Cons. H.S. / Lamar Jr. High

Dennis Fyke – Head AT

Krystal Tyree – Asst. AT

832-223-3160

Terry H.S. / George Jr. High

Kevin Roberts – Head AT

Cindy Tiegs – Asst. AT

832-223-3568

Churchill Fulshear H.S. / Leaman Jr. High

Phillip Reed – Head AT

Brittney Mitchell – Asst. AT

832-223-5117



El Departamento de Atletismo de Lamar quiere darle las gracias por tomarse el tiempo en completar las formas que requieren Lamar CISD y UIL para participar en el programa de atletismo. Todos los estudiantes atletas del 7° al 12° grado están obligados a llenar y presentar estos formularios en línea antes de comenzar el año escolar.

Lamar CISD y UIL requiere que el padre/ tutor legal, y el estudiante completen los formularios de participación cada año. Los padres y estudiantes deben leer y enviar los formularios de UIL, ya que tienen que ver con ellos. Los formlarios de este año se completarán en línea para hacer de este -un proceso conveniente para todas las familias. El enlace para la documentación en línea es:
<https://lamarcisd.rankonesport.com/>

La única forma obligatoria que no se puede hacer por vía electrónica es el historial anual físico y médico. Los padres podrán imprimir un historial físico y médico durante esa sesión electrónica. Se requiere que el estudiante utilice el formulario de pre-participación del examen físico previsto. **NINGUNA OTRA FORMA** del examen físico será aceptado de acuerdo al UIL. **Un examen físico nuevo debe realizarse antes de del comienzo del año escolar.** Cualquier examen físico administrado antes del 1 de mayo no tendrá validez después del 1 de agosto.

Todos los **formularios en línea** deben ser completados en su **totalidad**; y el formulario del examen físico debe ser devuelto al entrenador de educación física o al entrenador de atletismo antes que el estudiante participe en **cualquier** prueba, práctica, clase de atletismo, gimnasio abierto, sala de pesas abierta, competencia atlética, o cualquier viaje con el equipo deportivo de cualquier propósito.

Physical Dates – Spring 2017

Foster High School – 2 Mayo, 11:30 A.M. – 5:00 P.M.
Lamar Cons. High School – 3 Mayo, 8:00 A.M. – 3:00 P.M.
George Ranch High School – 10 Mayo, 8:00 A.M. – 4:00 P.M.
Terry High School – 21 Mayo, 11:00 A.M. – 3:00 P.M.
Churchill Fulshear High School – 22 Mayo, 2:30 P.M. – 5:30 P.M.

Foster H.S. / Briscoe Jr. High

Tiffany Kizziah – Head AT
Chandra Teague – Asst. AT
832-223-3970

George Ranch H.S. / Reading Jr. High

Lance Hale – Head AT
Shelby Jacobs – Asst. AT
832-223-4361

Lamar Cons. H.S. / Lamar Jr. High

Dennis Fyke – Head AT
Krystal Tyree – Asst. AT
832-223-3160

Terry H.S. / George Jr. High

Kevin Roberts – Head AT
Cindy Tiegs – Asst. AT
832-223-3568

Churchill Fulshear H.S. / Leaman Jr. High

Phillip Reed – Head AT
Brittney Mitchell – Asst. AT
832-223-5117

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 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 _____
 '19-'20 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.

<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? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 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 Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____ When was your last concussion? _____ How severe was each one? (Explain below) Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below:</p> <table border="0"> <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><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weight more or less than you do now? <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 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? _____ 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? _____</p> <p><i>Males Only</i></p> <p>20. Do you have two testicles? _____</p> <p>21. Do you have any testicular swelling or masses? _____</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	
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<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: _____

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 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*
MEDICAL			
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)			

MUSCULOSKELETAL

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.