

INSTRUCTIONS FOR FILLING OUT FWC PHYSICAL FORMS

***For the safety and protection of Fort Worth Christian School's athletic department and the athletes themselves, it is mandatory for all student-athletes, student trainers, team managers, and cheerleaders (grades 7-12) to complete a yearly athletic physical. No student athlete, trainer, manager, or cheerleader will be allowed to participate in any practices, games, or any organized team function until a current physical has been completed and turned into our athletic office. All physicals will be good for up to 1 year from the date of the examination.**

1. Prior to visiting your physician's office, print pages 2 and 3 of this document labeled **History** and the **Physical Examination**. It may be helpful for you to print out this instruction sheet so that you will complete all the necessary steps.
2. **HISTORY FORM:** This form must be completely filled out by a parent or legal guardian. Make sure that all questions are answered correctly and that a parent or legal guardian signs this form at the bottom. This form serves as a disclaimer and a medical release so that our coaches may initiate treatment for your child in an emergency or non-emergency situation.
3. **PHYSICAL EXAMINATION FORM:** This form must be completed by either a physician (MD or DO), physician assistant (PA), nurse practitioner (NCP), or chiropractor (DC). Please have one of these licensed professionals conduct the examination on your child and determine your child's playing status regarding athletics. Please have this medical professional sign and date this form.

*Once the physical is completed, bring all the forms to our athletic secretary, Mrs. Jenny Freytag, her office is located in the foyer of Cardinal gym. Along with the physical forms, your child may also need to complete additional paperwork required by our athletic department prior to participation. Please contact Mrs. Freytag at 817.520.6513 to find out what other paperwork is needed for completion.

Thank you for allowing your child to participate in Fort Worth Christian's athletic programs.

Corry Karlen ATC, LAT
Head Athletic Trainer
Fort Worth Christian School

Scott Smiley
Athletic Director/Head Football Coach
Fort Worth Christian School



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 **TAPPS** 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 NAME (PRINT): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____ PARENT CELL PHONE: _____

SCHOOL: _____ GRADE LEVEL: _____

PERSONAL PHYSICIAN: _____

PHYSICIAN PHONE: _____

In case of emergency contact:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	YES	NO
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any family member or relative died of heart problems before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member been diagnosed with Long QT Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has any family member been diagnosed with Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had a severe viral infections (myocarditis, mononucleosis, etc) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever experienced a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had numbness in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you currently taking any prescription or nonprescription medications or inhalers?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever been dizzy before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever become ill after exercising or working in the heat?	<input type="checkbox"/>	<input type="checkbox"/>

- | | YES | NO |
|--|--------------------------|--------------------------|
| 32. Have you ever had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you use any special protective or corrective equipment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Have you ever had a sprain, strain or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever broken or fractured any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please check the appropriate box and explain on separate sheet of paper.

- | | | | | | | | | | |
|-------|--------------------------|-----------|--------------------------|--------|--------------------------|------------|--------------------------|------|--------------------------|
| Head | <input type="checkbox"/> | Shoulder | <input type="checkbox"/> | Wrist | <input type="checkbox"/> | Thigh | <input type="checkbox"/> | Foot | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | Upper Arm | <input type="checkbox"/> | Hand | <input type="checkbox"/> | Knee | <input type="checkbox"/> | | |
| Back | <input type="checkbox"/> | Elbow | <input type="checkbox"/> | Finger | <input type="checkbox"/> | Shin/ Calf | <input type="checkbox"/> | | |
| Chest | <input type="checkbox"/> | Forearm | <input type="checkbox"/> | Hip | <input type="checkbox"/> | Ankle | <input type="checkbox"/> | | |

- | | | |
|---|--------------------------|--------------------------|
| 41. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you lose weight regularly to meet weight requirements for you Extra-Curricular Activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Females Only

- | | |
|---|------------|
| 45. When was your first menstrual period? | _____ |
| 46. When was your most recent menstrual period? | _____ |
| 47. How much time elapses from the start of one period to the start of another? | _____ days |
| 48. How many periods have you had in the last year? | _____ |
| 49. What was the longest time between period in the last year? | _____ days |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of accident still remains. Neither the **Texas Association of Private and Parochial Schools**, 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 illness, 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, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, in 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 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 and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.

STUDENT SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN NAME (PRINT): _____

PARENT SIGNATURE: _____ DATE: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____



PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION



STUDENT NAME (PRINT): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT: _____

PULSE: _____ BLOOD PRESSURE: ____/____ (____/____,____/____)

Brachial blood pressure while sitting

VISION: R 20/____ L 20/____ CORRECTED: YES ____ NO ____ PUPILS: EQUAL ____ UNEQUAL: ____

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation in the first and third years of high school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			

*Initials for station –based examination only

MUSULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other			

CLEARANCE

- Cleared for participation
- Cleared for participation after completing evaluation/ rehabilitation for: _____
- Not cleared for participation

Recommendations: _____

Provider Name: _____ Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____