AUSTIN INDEPENDENT SCHOOL DISTRICT (AISD)
2026-2027 MEDICAL HISTORY & PREPARTICIPATION PHYSICAL EVALUATION FORM

*SCHOOL (26-27)*___________________________

LAST NAME:____________________ FIRST NAME:____________________ SEX:____ DATE OF BIRTH:_______________ STUDENT ID #:___________________ GRADE (26-27): ________

ADDRESS:____ CITY:_____________________ ZIP CODE: _____________________ PHONE: ___________________________

EMERGENCY CONTACT : NAME: _______________________________________ PHONE: ___________________________ RELATIONSHIP TO STUDENT:_________________________________

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE, OR CONTEST BEFORE, DURING, OR AFTER SCHOOL, INCLUDING AN ATHLETIC PERIOD.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

#	*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 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 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 channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities 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 specific illness, injury, or medical condition?	☐	☐
7	Are you currently taking any prescription or non-prescription (over-the-counter) medication/pills?	☐	☐
8	Do you have any allergies (ex: to pollen, medicine, food, or stinging insects)?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
	Is an epipen required?	☐	☐
9	Have you ever been dizzy during or after exercise?	☐	☐
10	Do you have any current skin problems (ex: 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?	☐	☐
13	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Are you prescribed an inhaler?	☐	☐
14	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (ex: 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		
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 sickle cell disease?	☐	☐
19	Do you hae any other medical conditions not previously mentioned (ex: diabetes, thyroid disease, immune disorders, bleeding disorder, ADHD, mental health disorder, etc?)	☐	☐

Females Only — I choose not to provide written information on Question 20 but will discuss with a medical professional ☐

20
- 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 21 but will discuss with a medical professional ☐

21 Are you missing a testicle _____________ Do you have any testicular swelling or masses? _____________

☐ **OPTIONAL: An electrocardiogram (ECG) is not required.**
<u>By marking this box, I choose to obtain an ECG for my student. I understand it is the responsibility of my family to schedule and pay for such an ECG.</u> I have read and understood the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form.

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

PREPARTICIPATION PHYSICAL EVALUATION - PHYSICAL EXAMINATION

All students participating in athletics, marching band, cheerleading, drill team, and dance will be required to obtain a new physical exam **<u>dated after April 15, 2026</u>** prior to participating in any practice or activity for the 2026-2027 school year.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
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 pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only) if indicated			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

Height_________ **Weight**_________ **%Body Fat (opt)** ____ **BP**____/____, (____/____, ____/____) (brachial blood pressure while sitting)

Vision R 20/________ **L20/**________ **Corrected: Y N Pupils: Equal or Unequal Pulse**____________

CLEARANCE {Please check one}

☐ **Cleared (No restrictions)**

☐ Cleared **<u>AFTER</u>** completing evaluation/rehabilitation for:
____

☐ ***Not cleared for:***____

Reasons: ____

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 Exam: ________________________

Address: ____ Phone Number: _______________________

Signature: ____

*Austin ISD requires that each participant to have an annual physical dated after **April 15, 2026** to be eligible for the 26-27 school year.*

It is understood that even though protective equipment is worn by athletes, 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 participation, 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: ____

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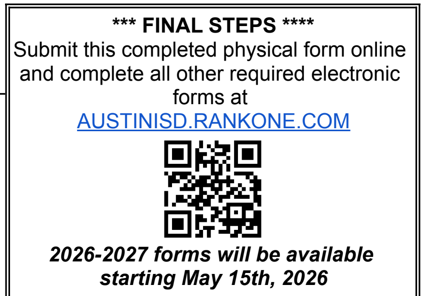
***** FINAL STEPS ******

Submit this completed physical form online and complete all other required electronic forms at [AUSTINISD.RANKONE.COM]



2026-2027 forms will be available starting May 15th, 2026

FOR AISD SCHOOL OFFICIAL USE ONLY. This form was reviewed by: Printed Name: ___________________________ Signature: ____________________________

2026-2027