



Commerce Athletic Training

To: Commerce ISD Student-Athletes and Parents

From: Amanda Herron MS, ATC, LAT
Head Athletic Trainer

Subject: Student-Athlete Pre-Season Forms

Attached are the instructions to complete the medical paperwork for participation in any athletic activities for the 2022-2023 athletic year. **ALL STUDENT-ATHLETES must complete the medical history and UIL forms prior to the start of your season to compete each year.** UIL forms will be completed electronically on RMA. Please keep in mind that this form is confidential and is for your benefit.

Physical Exam:

Needs to be completed by a Medical Doctor (**incoming 7th, 9th and 11th graders**). The physical form is attached. Physicals will be provided during the school day this spring free of charge. All forms must be completed prior to receiving a physical exam. Physical Date is April 27th, students will be bussed to Sulphur Springs. Physicals will be conducted by Christus Trinity Mother Frances Health System providers. If the Medical history and forms are not completed prior to 4/25/22 you will be responsible for getting your child a physical.

REGISTER MY ATHLETE(RMA):

New system that is more athletic department friendly. This program will allow us as an athletic department to complete rosters with UIL, transfer paperwork, injury tracking, and treatment sign ins. You will need to complete the 1 time registration for each of your athletes at the instructions and link below. There is also a link and instructions in the Parent Square message as well. Every athlete will need to complete a registration. Detailed instructions on the the reverse side. As a PARENT 1 Account, able to complete a profile for each Student-Athlete under your 1 parent account.

Instructions for RMA

Please use Google Chrome or Firefox to register.

1. Go to www.registermyathlete.com
2. Click **Login** in the upper right-hand corner
3. Click **Create Account**
4. Select that you will be using the site as a **Parent**.
5. Enter **PARENT INFORMATION**.
6. Click **Create an Account**
7. Click the **Parent button**
8. Click **Start/Complete a Registration** on the left side of the screen
9. Click **Start a New Registration**
10. Follow the prompts to register your athlete for a sport. Register each athlete 7-12th grades
****COMPLETE ALL of the forms and electronic signatures.**
11. **Complete a New Registration for EACH ATHLETE**

Return FORMS by APRIL 13thth to:

Amanda Herron at CHS.

Head Athletic Trainer

Office: 903.886.3756

Fax: 903.886.6209

Email: amanda.herron@commerceisd.org

2022-2023 UIL Athletic Participation Packet**Commerce ISD**Grade (2022-2023): _____
Gender:(circle) Female Male**Fill out completely in Blue or Black ink ONLY. Turn completed packet into the HS Front Office or Athletic Trainer.**

Must Turn in the packet and complete the REGISTER MY ATHLETE to be eligible for participation

BACKGROUND INFORMATION

Athlete Name: _____ SPORTS: _____
Cell Phone: _____ Date of Birth: _____
Home Address: _____ City: _____ Zip: _____
Parent/Guardian 1 Name: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____
Parent/Guardian 2 Name: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____

EMERGENCY INFORMATION (Other persons to call in case of emergency and parents cannot be reached.)

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Family Physician: _____ Phone: _____ Hospital Preference: _____
Allergies to medicine or other: Please list _____
Any medicine taking regularly OR other medical concerns: _____

Have you ever tested Positive for Sickle Cell Anemia, Sickle Cell Trait or any other blood disorder? **YES NO****MEDICAL CONSENT FOR TREATMENT**

I, the undersigned, the parent/guardian of _____ (name of minor), a minor, do hereby authorize the Commerce ISD District Staff as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of and licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment.

OTC MEDICATION DISTRIBUTION*All Medications will be administered in a single pre-packaged dose per medication directions.*

As parent/ legal guardian of my child, I have read the policies pertaining to school personnel administering medication and this is your permission to administer medication to my child. I understand and agree that my signature on this form constitutes a waiver of liability. I further acknowledge and agree that when the below medication(s) is administered, I waive any claim I might have against CISD and its employees arising out of administration of said medication. In addition, I agree to hold harmless and indemnify CISD and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication(s).

*****Please provide the athletic trainer with an extra inhaler/epi-pen if needed during physical activity.*****Circle Yes or No for each medication:**

| | | | | | | | | |
|--------------|-----|----|--------------|-----|----|-----------|-----|----|
| Pepto Bismol | YES | NO | Advil | YES | NO | Alieve | YES | NO |
| Tums | YES | NO | Tylenol Cold | YES | NO | Ibuprofen | YES | NO |
| Tylenol | YES | NO | Benedryl | YES | NO | Midol | YES | NO |

Circle one of the following: Administer Medication as needed | Call before administering medication**By signing below I attest that all information is correct and accurate. I agree to medical consent for treatment and OTC medication distribution.**

Parent/Guardian Signature

Phone Number

Date

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 that would make it hazardous to participate in an athletic event.

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

Address _____ Student's Phone: _____

Grade (22-23) _____ School _____ Sports _____

Personal Physician: _____ Phone: _____

In case of emergency, contact:

Name: _____ Relationship _____ Phone (C): _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

| | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had prior testing for the heart ordered by a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you use any special protective for corrective equipment or devices that aren't usually used for sports for position (ie. Knee brace, neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had your heart race or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, check the appropriate box and explained below: | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip | | |
| Had any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc) Marfan's Syndrome, or abnormal heart rhythm? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh | | |
| Have you ever had a severe viral infection (ie. Myocarditis, or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee | | |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf | | |
| 4. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle | | |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot <input type="checkbox"/> Toe | | |
| If, yes, how many times? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you want to weigh more or less than you do? | | |
| When was your last concussion? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| How severe was each one? (Explain in "Yes" box) | | | 21. Have you ever been tested for sickle cell disease or trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever been diagnosed with or treated for sickle cell trait or disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Do any family members carry or have sickle cell anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | <i>Females Only</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have diabetes? Or require insulin? | <input type="checkbox"/> | <input type="checkbox"/> | 24. When was your first menstrual period? _____ | | |
| 6. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | When was your most recent menstrual period? _____ | | |
| 7. Are you missing any paired organs? | <input type="checkbox"/> | <input type="checkbox"/> | How much time do you usually have from the start of one period to the start of another? _____ | | |
| 8. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | How many periods have you had in the last year? _____ | | |
| 9. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 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. | | |
| 10. Do you have any allergies (ie. To pollen, medicine, food, or insect stings)? | <input type="checkbox"/> | <input type="checkbox"/> | ** Explain "YES" answers in the box below (attach another sheet if necessary): <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> | | |
| 11. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. Do you have any current skin problems (ie. Itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Do you have ADD/ADHD/Learning Disability? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither is the UIL nor the school assumes any responsibility.

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 might 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. I acknowledge and agree that all information on UIL required online forms is accurate and correct, including all electronic signatures. As guardian, I take full responsibility for reading and completing UIL forms with my child. The above student may receive a provided physical examination during school hours by a licensed provider unaccompanied by parent or guardian.

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 exam. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, game or match. 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 _____ Gender _____ Age _____ Date of Birth _____
Height _____ Weight _____ Pulse _____ Blood Pressure _____/_____/_____ (____/____, ____/____)
Vision: R 20/____ L 20/____ Corrected: ☐ YES ☐ NO Pupils: ☐ EQUAL ☐ UNEQUAL

As a requirement of Commerce ISD, this PHYSICAL EXAM FORM **must** be completed prior to athletic participation each year (7-12th grades).

| MEDICAL | NORMAL | ABNORMAL FINDINGS | INITIAL* |
|--|--------|-------------------|----------|
| 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 | | | |
| Sickle Cell Trait Testing* | | | |
| Marfan's Stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) | | | |

MUSCULOSKELETAL

| | | | |
|------------------|--|--|--|
| Neck | | | |
| Spinal Screening | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

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 the State of Physician Assistant Examiners, a Advanced Practice Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination form signed by any other healthcare practitioners will not be accepted.

Name (Print): _____ Exam Date: _____

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.