Dear Parents,

You may begin submitting forms for the **2024-2025** school year on **Monday April 22nd.** Any forms submitted prior to April 22nd, will have to be resubmitted.

Athletic link to online paperwork is: https://katyisd.rankonesport.com/

- **High School Athletes need**
  - Physical
  - Medical History
  - Handbook Acknowledgement Form
  - Katy ISD Consent to Treat
  - UIL Forms Signature Page
  - Bonafide Residence
  - Utility Bill (Gas, Electric or Water only)

- **Junior High Athletes need**
  - Physical
  - Medical History
  - Handbook Acknowledgement Form
  - Katy ISD Consent to Treat
  - UIL Forms Signature Page

Fine Arts link to online paperwork is: https://katyisd-finearts.rankonesport.com/

The physical form must be completed by a physician and dated after May 1st, 2024, to be valid for the 2024-2025 school year.

The UIL physical form now includes a notification of the option of a student to request the administration of an electrocardiogram. When the box is checked yes for ECG, it is the responsibility of the parent to having an ECG conducted. The Katy ISD Athletic Department recommends that students and parents consult with their family physician regarding the need of an ECG. Indication of the intent to obtain an ECG will not prohibit participation. Participation will not allow once a medical professional restricts the student from physical activity. For more information on the new PPE form and its requirements please go to https://www.uiltexas.org/athletics/page/pre-participation-physical-evaluation

If you encounter any problems trying to submit your forms online, please contact the campus athletic trainer. Campus contact information can be found on the athletics page of Katy ISD website.
https://www.katyisd.org/dept/athletics/Pages/Campus-Contacts.aspx

Katy Independent School District Physical and ECG Examinations

Physical examinations will only be given to KISD student athletes participating in UIL activities grades 7-12. The UIL physical form will be the only physical form accepted.

ECG examination will only be given to students participating in UIL activities grades 9-12. All ECG examinations will be an additional cost. ECG examinations will need to have parent or guardian consent.

Although KISD recommends the use of your family doctor for the physical examination, the following mass screenings are available as an economical convenience for its patrons. KISD sponsored physical examinations will be performed by the **Medical Colleges of Texas at a nominal fee of $30.**

2024-2025 ECG and Physical Schedule

Date	Facility	Location	Physical Time	ECG Time
Tuesday, April 30, 2024	MCHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday May 1, 2024	SLHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Thursday, May 2, 2024	PHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Monday, May 6, 2024	MRHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Tuesday, May 7, 2024	BDJH	Competition Gym	5:30pm-6:15pm	
Wednesday, May 8, 2024	WCJH	Competition Gym	5:30pm-6:15pm	
Tuesday, May 14, 2024	OTHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday, May 15, 2024	THS	Gym 4	5:30pm-6:15pm	3pm - 5:30pm
Thursday, May 16, 2024	KHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Tuesday, May 21, 2024	JHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday , May 22, 2024	CRHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Tuesday, July 23, 2024	OTHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday, July 24, 2024	JHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Thursday, July 25, 2024	KHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Monday, July 29, 2024	THS	Gym 4	5:30pm-6:15pm	3pm - 5:30pm
Tuesday, July 30, 2024	MCHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday, July 31, 2024	PHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Monday, August 5, 2024	CRHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Wednesday, August 7, 2024	MRHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Thursday, August 8, 2024	SLHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Monday, August 12, 2024	FHS	Competition Gym	5:30pm-6:15pm	3pm - 5:30pm
Thursday, August 15, 2024	Legacy	Community Room	5:30pm-6:15pm	3pm - 5:30pm
Friday, August 16, 2024	Legacy	Community Room	5:30pm-6:15pm	3pm - 5:30pm

All payments will be onsite accepting cash, checks and credit card by phone

ECG examinations will begin at 3pm at the site listed for that day only for $20. (Separate fee).

Confirmation of Understanding of Limited Scope and Purpose of the Extra-Curricular/Co-Curricular Pre-Participation Physical Exams

I, ---------- . (Print Parent/Legal Guardian Name) am aware that my child/ward, __ (Print Child's Name), will attend an event providing pre-participation physical exams for student athletes at _ _ _ _ _ _ _ on - - - ___, 20_ ("the event"). The event is sponsored Katy ISD for the sole purpose of clearing students for participation in extra-curricular/cocurricular programs. The screening physical exam will be performed by contracted healthcare providers from Medical Colleagues of Texas. By signing this form, I am confirming I understand and agree to the following:

- I consent to the extra-curricular/co-curricular physical exam for the above-named child.
- This is NOT a comprehensive physical exam and should not take the place of routine medical care;
- I understand that this is a screening physical for clearance for participation in extracurricular/co-curricular activities ONLY;
- Any patient-physician relationship created during the event will terminate immediately upon completion of the screening physical;
- I understand that my child may need additional testing before/he can be cleared for participation in athletic activities and it is my sole responsibility to obtain such additional testing or medical care: I understand that if it is determined that my child needs additional medical treatment; I will be notified of any such recommendation. I understand that a limited number of non-invasive tests may be available and performed at the event for my convenience; I consent to any and all additional noninvasive testing as deemed necessary by the screening physician during the event without notification to me prior to the testing;
- Notwithstanding the foregoing, per KISD directives, an evaluation or palpation of the femoral pulse for coarctation of the aorta will not be included during this preparticipation regardless of necessity. I understand have the option to arrange for my child's primary care physician or an alternative, licensed medical professional to perform the preparticipation physical during which they may perform this evaluation.
- I consent to the release of the results of my child's physical screening exam to his or her school (including a coach, athletic trainer, teacher or administrator) present at the event. This consent remains valid unless revoked by me which can be done at any time. I understand that the information released may not be protected by law once it is disclosed and may be subject to re-disclosure by the Recipient.

Parent/Guardian's Signature Date

RELEASE FROM LIABILITY AND INDEMNIFICATION

I hereby release, waive, discharge and covenant not to sue Medical Colleagues of Texas and its subsidiaries, officers, directors, trustees, employees, agents and affiliated companies from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be caused by or related to my child's participation or presence at the extra-curricular/co-curricular Physical Examination Event. I understand that I acknowledge that I have read and understand the foregoing Release and that my signature below acknowledges the statements made in the Release.

Parent/Guardian's Signature Date

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

2024

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

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

Address _____ Phone _____

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.

		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 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 unexplained 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 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?	☐	☐
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 activity 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 sickle 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. I have read and understand the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checking this box, I choose to obtain an ECG for my student for additional 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 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: _____

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, PERFORMANCE 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 participation and again prior to first and third years of high school 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) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

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 performance/ games/matches.