Dear Student:

The Superintendent would like to take this opportunity to welcome you to the Brownsville Independent School District. We hope this letter will aid in the process of completing all necessary health forms to participate in the University Interscholastic League, extracurricular programs, and/or the Brownsville Academic Center. For the 2018-2019 school year, any student participating in University Interscholastic League, extracurricular programs, and/or alternative educational programs, will be required to have a physical on file prior to participation which includes all practices. Physicals are valid for one school year. This packet includes the following forms:

Pre-Participation Medical History and Pre-Participation Physical
The Medical History Form must be completed annually by parent and/or guardian and student in order for the student to participate. The questions are designed to determine if the student has developed any condition which would make it hazardous to participate. The Pre-Participation Physical Form must be on file for each student before the first day of participation. This physical MUST be completed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner will not be accepted. The physician must sign and print their name in the space provided.

Physical Exam Providers
Below are several options where you can take your child for a physical:

- Your family physician
- Valley Day & Night Clinics
- BISD Campus Care Centers at Skinner and Lincoln Park
- New Horizon Medical Center
- Operation Lone Star (To Be Announced)

For a list of additional providers, contact your coach, director, and/or program sponsor.

Immunizations
Immunizations are required to assist in the health and well-being of student participation. The immunizations are required of all students and are consistent with the Texas Department of Health and local BISD policies. Refer to your designated campus nurse for updates on immunizations.

Emergency Information
All sections must be completed. If you have a medical insurance plan that is an HMO/PPO and you are not from the Brownsville area, it is advised that you designate a local physician as your primary care physician. This will assist in the event a medical referral is necessary for an injury or illness.

Health Insurance
Medical insurance is required of all students participating in University Interscholastic League, extracurricular programs, and/or the Brownsville Academic Center in case of injuries. If your insurance does not cover injuries during your participation, you will be financially responsible for any and all medical costs associated with any injuries. You must provide a photocopy of the front and back of your insurance card when you submit the packet. The District also provides affordable Student Accident Insurance which can be purchased at the families' expense. You may view the Voluntary Optional Student Accident insurance's coverage by visiting the Monarch Management Corporation website (http://www.mmc-ins.com) or calling the Employee Benefits / Risk Management Department at 956-548-8061.

Secondary Insurance Coverage
The Brownsville Independent School District provides an insurance coverage for all students involved in University Interscholastic League and/or extracurricular programs for grades 6-12. The insurance coverage that is provided is supplemental to the student's personal insurance. Once the primary insurance has paid its benefits, the BISD insurance will pay at a **REASONABLE AND CUSTOMARY RATE** of the remaining balance. If the student has no insurance, then BISD insurance becomes primary and will pay at a **REASONABLE AND CUSTOMARY RATE UP TO POLICY LIMITS**. It must be understood that after reasonable and customary benefits have been met, there still may be a balance due that must be paid, unless the physician is a member of the network. Physicians within the network provide zero balance billing. Trainers will have a list of the in-network providers. **THE PARENT/GUARDIAN IS RESPONSIBLE FOR ALL COSTS NOT COVERED BY THE INSURANCE PROVIDED**. Charges for treatment of injuries shall not be charged to BISD or any employee of BISD. It is the responsibility of the parent/guardian to file with the insurance. It is also the responsibility of the parent/guardian to notify BISD Personnel regarding any and all medical services for injuries received by the participant. The Brownsville Independent School District **WILL NOT** be held responsible for medical or other costs related to injuries received by the participant except to provide the insurance coverage as outlined above.

No student will be permitted to participate in any practices, University Interscholastic League approved sports, marching band, extracurricular programs, and/or alternative educational programs prior to all documents being on file with BISD.

If you have any questions in regards to any of the information listed above, please contact your coach, director, and/or program sponsor. Best of luck to all of you!

 BISD does not discriminate on basis of race, national origin, sex, religion, age, or disability in employment or provision of services, programs, or activities.

Brownsville Independent School District Participation Form for Secondary Programs

Name of Student: ___________________________________ School ID#:________________ Grade: ____________________

Sex (circle one): M F DOB: ______________________________ School: ____

Name of Parent or Guardian: ___________________________________ Address: _________________________________

Home phone: ________________________ Work phone: _____________________________ Cell phone: _________________

Attention School Authorities: This form and all other inserts that pertain to your program must be updated and signed annually by both the student and parent/guardian and be on file at your school before the student may participate in any practice session or contest before, during, or after school.

Parents' or Guardians' Permit For Student Participation

I hereby give my consent for the above student to participate in University Interscholastic League approved sports, marching band, extracurricular programs, and/or alternative educational programs. The student will be allowed to travel with the coaches, directors, or other representative of the school on any approved trips in which the student is eligible.

It is understood that even though precautionary measures are taken whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the Brownsville Independent School District assumes any responsibility in case an accident occurs.

I have read and understand the University Interscholastic League rules included in this packet and agree that my son/daughter will abide by all of the University Interscholastic League rules and/or program requirements.

The undersigned agrees to be responsible for the safe return of all athletic equipment and/or uniforms issued by the school to the above named student. If, in the judgment of any representatives of the school, the above student needs 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 to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whosoever on account of such care and treatment of said student.

The UIL Athletic Parent Information Manual is located at www.uiltexas.org/files/athletics/manuals/parent-information-manual.pdf.
The UIL Music Resources are located at www.uiltexas.org/music/resources-forms

Your signature below gives authorization that is necessary for the school district, its licensed athletic trainers, coaches, associated physicians and student insurance personnel to share information concerning medical diagnosis and treatment for your student.

Circle any activity in which this student is allowed to participate:

Baseball Basketball Cross Country Football Golf Soccer Softball Swimming/Diving Tennis Track Volleyball Powerlifting

Marching Band Cheerleading Dance Team BAC

_____________________________________ ____
Parent/Guardian Signature Date

_____________________________________ ____
Student Signature Date

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Brownsville Independent School District
Participation Form for Secondary Programs

Pre-Participation Medical History Form

Name of Student: ____ School ID#:___________________ Grade: ________________________
Sex (circle one): M F DOB: ______________________________ School: ____
Name of Parent or Guardian: ____________________________________ Address: ____
Home phone: ___________________________ Work phone: ____________________________ Cell phone: ______________________________
Personal Physician: ____ Phone: ____
In case of emergency, contact:
Name: ________________________________ Relationship: ____________________ Phone: (cell)__________________ (other) ______________

Explain "Yes" answers in the box below.** Circle questions you don't know the answers to. Any "Yes" answers to questions 3-12 requires further medical evaluation. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in any practices, University Interscholastic League approved sports, marching band, extracurricular programs, and/or alternative educational programs.

	Yes	No
1. Have you ever had a medical illness or injury since your last check up or physical?		
2. Have you been hospitalized overnight in the past year?		
3. Have you ever passed out during or after exercise?		
4. Have you ever had a chest pain during or after exercise?		
5. Have you ever had racing of your heart or skipped heartbeats?		
6. Do you get tired more quickly than your friends do during exercise?		
7. Have you had high blood pressure or high cholesterol?		
8. Have you ever been told you have a heart murmur?		
9. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?		
10. 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?		
11. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
12. Has a physician ever denied or restricted your participation in physical activities for any heart problems?		
13. Have you ever had a head injury or concussion?		
14. Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times: When was the last concussion? How severe was each one (explain below)?		
15. Have you ever had a seizure?		
16. Do you have frequent or severe headaches?		
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
18. Have you ever had a stinger, burner, or pinched nerve?		
19. Are you missing any paired organs?		
20. Are you currently under a doctor's care?		
21. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler?		
22. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
23. Have you ever been dizzy during or after exercise?		
24. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
25. Have you ever become ill from exercising in the heat?		
26. Have you had any problems with your eyes or vision?		

	Yes	No
27. Have you ever gotten unexpectedly short of breath with exercise?		
28. Do you have asthma?		
29. Do you have seasonal allergies that require medical treatment?		
30. 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)?		
31. Have you ever had a sprain, strain, or swelling after an injury?		
32. Have you broken or fractured any bones or dislocated any joints?		
33. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, **circle** the areas and explain below. Head Chest Elbow Hand Thigh Ankle / Neck Shoulder Forearm Finger Knee Foot / Back Upper Arm Wrist Hip Shin/Calf		
34. Do you want to weigh more or less than you do now (circle one)?	More	Less
35. Do you feel stressed out?		
36. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		

For Females Only:
37. 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? ______________

For Males Only:
38. Do you have two testicles? _____________
39. Do you have any testicular swelling or masses? _________________

An individual answering "Yes" to any question 3-12, relating to a possible cardiovascular health issue as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, or nurse practitioner.

****EXPLAIN "YES" ANSWERS IN THE AREA BELOW** (attach another sheet if necessary):
____
____
____
____

It is understood that even though protective equipment is worn by the student, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school district 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 a person on account of such care and treatment of said.

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: ___________________

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, OR CONTEST BEFORE, DURING, OR AFTER SCHOOL.

For School Use Only:
This Medical History Form was reviewed by: Printed Name: ____________________________ Title: ____
Signature: _______________________________ Date: ____

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Brownsville Independent School District
Participation Form for Secondary Programs

Pre-Participation Physical Examination Form

Student's Name: ___________________________________ Sex (circle one): M F Age: _______ Date of Birth: ___________________

Height: __________ Weight: _________ % Body Fat (optional): __________ Pulse: ______________ BP: ____/____ (____/____, ____/____)
Brachial blood pressure while sitting

Vision: R 20/______ L 20/______ Corrected Lenses (circle one): Yes No Contact Lenses (circle one): Yes No Pupils (circle one): Equal Unequal

The Brownsville Independent School District requires any student participating in University Interscholastic League and/or extracurricular programs to have a physical examination annually.

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: Ausculation of the heart in the supine position			
Heart: Ausculation 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			

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, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioners will <u>not</u> be accepted.

Exam Completed by (Name): __________________________ Medical Provider ID#: ____________________ Date of Examination: ______________

Address: ____ Phone Number: ___________________________

Signature: ____

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