

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 ID# Grade Entering ('26-'27) School Sport 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.

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? 3. Have you ever had surgery? 4. Have you ever had prior testing for the heart ordered by a physician? 5. Have you ever passed out during or after exercise? 6. Have you ever had chest pain during or after exercise? 7. Do you get tired more quickly than your friends do during exercise? 8. Have you ever had racing of your heart or skipped heartbeats? 9. Have you had high blood pressure or high cholesterol? 10. Have you ever been told you have a heart murmur? 11. Has any family member or relative died of heart problems or of sudden unexplained death before age 50? 12. 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? 13. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? 14. Has a physician ever denied or restricted your participation in activities for any heart problems? 15. Have you ever had a head injury or concussion? 16. Have you ever been knocked out, become unconscious, or lost your memory? 17. If yes, how many times? 18. When was your last concussion? 19. How severe was each one? (Explain below) 20. Have you ever had a seizure? 21. Do you have frequent or severe headaches? 22. Have you ever had numbness or tingling in your arms, hands, legs or feet? 23. Have you ever had a stinger, burner, or pinched nerve? 24. Are you missing any paired organs? 25. Are you under a doctor's care? 26. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? 27. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? 28. Have you ever been dizzy during or after exercise? 29. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? 30. Have you ever become ill from exercising in the heat? 31. Have you had any problems with your eyes or vision? 32. Have you ever gotten unexpectedly short of breath with exercise? 33. Do you have asthma? 34. Do you have seasonal allergies that require medical treatment? 35. 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)? 36. Have you ever had a sprain, strain, or swelling after injury? 37. Have you broken or fractured any bones or dislocated any joints? 38. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? 39. If yes, check appropriate box and explain below: 40. Do you want to weigh more or less than you do now? 41. Do you feel stressed out? 42. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? Females Only: 43. I choose not to provide written information on Question 19 but will discuss with a medical professional: 44. When was your first menstrual period? 45. When was your most recent menstrual period? 46. How much time do you usually have from the start of one period to the start of another? 47. How many periods have you had in the last year? 48. What was the longest time between periods in the last year? Males Only: 49. I choose not to provide written information on Question 20 but will discuss with a medical professional: 50. Are you missing a testicle? 51. Do you have any testicular swelling or masses? 52. 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. 53. 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.

ELECTROCARDIOGRAM SCREEN (ECG) CONSENT FORM AND RELEASE OF LIABILITY

An ECG screen (sometimes also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screen may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

As per HB 76 of the 86th Texas Legislature a parent can elect to have their child receive an ECG. Cypress Fairbanks currently has an ECG program and will provide a free ECG the first year a student elects to receive one. Any sequential ECG's will be at the expense of the parents or guardian of the student and done outside of the school. We also ask that if you do an ECG out of the school district, that you share any abnormal results with the school district to ensure the safe participation in athletics of your child.

By signing below, I am either electing or declining an ECG screen provided by the Cypress-Fairbanks Independent School District for my child. By electing to receive an ECG screen, I acknowledge the limitations of an ECG screen and that sudden cardiac death may still occur, despite this screening. I further acknowledge that students with an abnormal ECG screen will be required to perform further testing (i.e., an echo or ultrasound) and/or a medical consultation prior to being released to resume participation for CFISD activities, at the parent's expense. By my signature below, I hereby release and forever discharge, and waive, any and all claims against the Cypress-Fairbanks Independent School District, its employees, trustees, consultants and contractors that relate to the student's election regarding and/or participation in the ECG screening project, and authorize medical personnel to review the ECG results, and interpret and use the same for diagnostic and aggregated statistical purposes in addition to other medical documentation on file in with the school district, and in accordance with the Family Educational Privacy Rights Act and the Health Insurance Portability and Accountability Act of 1996.

I DO hereby consent to participation in the ECG screen on behalf or that of my minor child.

I DECLINE participation in the ECG screen on behalf or that of my minor child.

Child's Name Printed _____

Date _____

X

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

PARENT E-MAIL ADDRESS _____

INFORMATION

STUDENT ID #: _____ NAME _____

AGE: _____ GENDER: MALE _____ FEMALE _____ BIRTHDATE: ____/____/____

GRADE: _____ HT: _____ WT: _____

CIRCLE HIGH SCHOOL ATTENDING 2026-2027:

- | | | | | | |
|-----------------|-------------------|-----------------|-----------------------|----------------------|-------------------|
| Cy-Creek | Cy-Fair | Cy-Falls | Cy-Lakes | Cy-Park | Cy-Ranch |
| Cy-Ridge | Cy-Springs | Cy-Woods | Jersey Village | Langham Creek | Bridgeland |

*This section to be completed by Athletic Trainer
DATE ECG COMPLETED*

_____/_____/_____



Cypress-Fairbanks Independent School District

Parent Permission for School-Sponsored Activity

with District transportation without District transportation

Cypress Creek High School

Student Name

Campus

Grade

Parent/Guardian

() -
Primary Phone

() -
Secondary Phone

Secondary Emergency Contact

() -
Primary Phone

() -
Secondary Phone

ACTIVITY: Football Games, Marching Band Rehearsals/Performances, UIL and Non-UIL Events.

PARENT ACKNOWLEDGMENT: In order for your student to participate in this school-sponsored activity, written parent permission is required below. Student safety is a high priority; however, under state law the school district is not responsible for medical or other costs associated with a student injury, unless the injury results from a school employee's negligent operation of a District vehicle. By completing and returning this form, you are authorizing your student to participate in the school-sponsored activity described above and acknowledge that you are responsible for any medical or other costs associated with a student injury that may occur during the activity, except as stated above. Students are required to use District-provided transportation if it is provided as indicated above (unless the campus principal or designee has specifically authorized a student to arrive or depart separately and the parent/guardian has completed any additionally required written permissions). The District shall not be liable or responsible for any action, injuries or damages that occur to students riding in vehicles that are not provided by the District.

If the above student needs immediate care and treatment as a result of injury or illness, I authorize CFISD employees to deliver or consent to care.

PRESCRIPTION MEDICATION ADMINISTRATION: Prescription medications administered by the school nurse during a regular school day will be transported/administered by the field trip sponsor for an activity limited to regular school hours.

Parent/Legal Guardian Signature ____/____/20____
Date

Complete this section ONLY if your child requires the administration of a prescription medication during an activity **extending beyond the regular school day**, please list the medication(s) you authorize CFISD staff members to administer in the table below. The field trip sponsor will provide instructions for parents/guardians to drop-off required medication(s) before the event. In accordance with CFISD Board policy FFAC (LOCAL), medication must be supplied in the original container (labeled for the student), and students may not transport medications to or from school or a school-sponsored event.

Medication Name	Dose	Route	Time

Parent/Legal Guardian Signature ____/____/20____
Date



Fine Arts Field Trip
High School

Cypress Creek High School

Student Name _____

Campus _____

Grade _____

Please provide a copy of the student's current insurance card.

Name of Insurance Company _____

Identification Number _____

Group Number _____

In case of a student emergency, CFISD employees should be knowledgeable of your child's medical conditions to provide safe care. Please list any medical conditions or regular medications below.

Asthma Diabetes Seizure Disorder List Severe Food Allergies _____

Daily and Emergency Medications: _____

Other Information: _____

District Provided Non-prescription Medication Permission

Authorization is hereby given for the administration of the following district provided non-prescription medications to my child by designated school employees. Circle Yes or No in last column.

Symptom	Medication	Brand Name	Circle Yes or No
Allergic Reaction	Diphenhydramine	Benadryl	Yes or No
Mild Pain/Fever	Ibuprofen	Addaprin, Motrin	Yes or No
Mild Pain/Fever	Acetaminophen	Tylenol	Yes or No
Mild Abdominal Pain Heartburn, Nausea	Calcium Carbonate Chews	Tums, Maalox	Yes or No

_____/_____/20_____
Parent/Legal Guardian Signature

Medication Log (For CFISD Use Only)

Date: (Month/Day)	Time	Signs & Symptoms	Medication Dispensed	Initials
/				
/				
/				
/				
/				
/				

**PARENT/STUDENT UIL MARCHING BAND
ACKNOWLEDGEMENT FORM**

Updated 2025

No student may be required to attend a marching band related practice for more than eight hours outside the academic school day per calendar week (Sunday through Saturday). This provision applies to students in all components of the marching band. **Exceptions:** For schools that begin instruction prior to the fourth Monday in August the limit of eight hours of rehearsal outside of the academic school day per calendar week shall begin on the Tuesday immediately following Labor Day. Schools under this exception shall be limited to eight hours of rehearsal outside of the academic day per school week (12:01 AM on the first day of school of the calendar week through the end of the school day on the last day of instruction of the school week) until the Tuesday immediately following Labor Day. For any calendar week consisting of less than five school days a marching band may rehearse one additional hour beyond eight hours for each non-school day, provided the school week limitation of eight hours is not exceeded.

On performance days (football games, competitions and other public performances) bands may hold up to one additional hour of warm-up and practice beyond the scheduled warm-up time. Multiple performances on the same day do not allow for additional practice and/or warm-up time.

Examples of Activities Subject to the UIL Marching Band Eight Hour Rule.

- Marching Band Rehearsal (Both Full Band and Components)
- Any Marching Band Group Instructional Activity
- Breaks
- Announcements
- Debriefing and Viewing Marching Band Videos
- Passing Off Marching Band Music
- Marching Band Sectionals (Both Director and Student Led)
- Clinics for The Marching Band or Any of its Components

The Following Activities Are Not Included in the Eight Hour Time Allotment:

- Travel Time to and From Rehearsals and/or Performances
- Rehearsal Set-Up Time
- Pep Rallies, Parades and Other Public Performances
- Instruction and Practice For Music Activities Other Than Marching Band And Its Components

NOTE: More information about Marching Band practice limitations can be found at:

www.uiltexas.org/music/marching-band

“We have read and understand the Eight-Hour Rule for Marching Band as stated above and agree to abide by these regulations.”

Parent Signature _____ Date _____

Student Signature _____ Date _____

This form is to be kept on file by the local school district.