



Brownsville Independent School District
Participation Form for Secondary Programs

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 2015-2016 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 Elementary and Campus Care Clinic @ Clinica 22
- New Horizon Medical Center
- Operation Lone Star (Manzano Middle School: July 27-31, 2015)

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 request a copy of this insurance plan and forms by 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!



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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: 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			
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 not be accepted.

Name (please print): _____ Date of Examination: _____

Address: _____ Phone Number: _____

Signature: _____

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



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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		Yes	No
1. Have you ever had a medical illness or injury since your last check up or physical?			27. Have you ever gotten unexpectedly short of breath with exercise?		
2. Have you been hospitalized overnight in the past year?			28. Do you have asthma?		
3. Have you ever passed out during or after exercise?			29. Do you have seasonal allergies that require medical treatment?		
4. Have you ever had a chest pain during or after exercise?			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)?		
5. Have you ever had racing of your heart or skipped heartbeats?			31. Have you ever had a sprain, strain, or swelling after an injury?		
6. Do you get tired more quickly than your friends do during exercise?			32. Have you broken or fractured any bones or dislocated any joints?		
7. Have you had high blood pressure or high cholesterol?			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.		
8. Have you ever been told you have a heart murmur?			Head Chest Elbow Hand Thigh Ankle		
9. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?			Neck Shoulder Forearm Finger Knee Foot		
10. 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?			Back Upper Arm Wrist Hip Shin/Calf		
11. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?			34. Do you want to weigh more or less than you do now (circle one)?	More	Less
12. Has a physician ever denied or restricted your participation in physical activities for any heart problems?			35. Do you feel stressed out?		
13. Have you ever had a head injury or concussion?			36. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		
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)?			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? _____		
15. Have you ever had a seizure?			How many periods have you had in the last year? _____		
16. Do you have frequent or severe headaches?			What was the longest time between periods in the last year? _____		
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet?			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.		
18. Have you ever had a stinger, burner, or pinched nerve?			**EXPLAIN "YES" ANSWERS IN THE AREA BELOW (attach another sheet if necessary): _____		
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?					

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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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 whatsoever on account of such care and treatment of said student.

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



PARENT/STUDENT UIL MARCHING BAND ACKNOWLEDGEMENT FORM



No student may be required to attend practice for marching band for more than eight hours of rehearsal outside the academic school day per calendar week (Sunday through Saturday). This provision applies to students in all components of the marching band.

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 at the performance site. 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
- Playing 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: An extensive Q&A for the Eight Hour Rule for Marching Band can be found on the Music Page of the UIL Web Site at: www.uil.utexas.edu

"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.



Emergency Information Form

Last Name First Name ID# DOB Teacher/Grade

Address

Mother/Guardian Home/Cell Number Work Number

Father/Guardian Home/Cell Number Work Number

Insurance Company: _____

Type of Coverage: Basic (circle one): Yes No Major Medical (circle one): Yes No

Deductible (optional): _____ Policy/Group Number (optional): _____

Contact Lenses (circle one): Yes No

1. Is your child currently taking any medications prescribed by a doctor (circle one)? Yes No If yes, please list medications and reasons for taking them. _____

2. Does your child have any allergic reactions to any type of medication (circle one)? Yes No If yes, please list. _____

3. Does your child have any type of medical condition for which we should be notified (circle one)? Yes No If yes, please list. _____

PARENT OF GUARDIAN'S PERMIT

The parent herewith grants permission for school employees to secure medical services for the above named student if necessary. Permission is hereby granted to the attending physician to proceed with any above named student. In the event of surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student will be given.

Signature of Parent/Guardian: _____ Date: _____

