

Please fill out, sign, and date by your Parent(s)/Guardian(s) and return As Soon As Possible.

## WHS Band Parent/Guardian Transportation Permission Form

We, as parents/guardians have given our permission for our son/daughter to make any trips necessary for participation in the activities of the Waltrip High School Band program. We understand that our child will be traveling by means of Houston ISD transportation or other HISD approved transportation. Our child has assured us that he/she will conduct herself/himself in such a way as to give credit to our school and community. We know each trip is an approved school trip and we understand that school rule of conduct and dress code will apply throughout each trip. We are aware that the district policy on dress is required for every trip. It is understood that precautions will be taken in the best interest of the student's safety and well-being. We agree that the faculty members, sponsors, and other adult chaperones that are going will not be held responsible for any accident or misfortune, which might occur in connection with any trip.

The faculty member or sponsor has my consent to give permission to any emergency medical treatment needs for my child. You may be assured that my child is being allowed to take each trip with our full consent.

Date \_\_\_\_\_

Parent/Guardian Signature x \_\_\_\_\_

As a Band Student, I have read this and will abide by these requirements.

Band Student Signature x \_\_\_\_\_

Band Student Printed Name \_\_\_\_\_

### Student Medical Information Form

(Please Print)

Home Phone Number \_\_\_\_\_

Emergency Name and Number \_\_\_\_\_

\_\_\_\_\_

What Allergies or Medications? \_\_\_\_\_

\_\_\_\_\_

Student's Physician and Number \_\_\_\_\_

\_\_\_\_\_

Hospitalization and Accident Insurance Policy (Please give the name of the companies and policy numbers)

Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Telephone \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's SS# \_\_\_\_\_



## HOUSTON INDEPENDENT SCHOOL DISTRICT

HATTIE MAE WHITE EDUCATIONAL SUPPORT CENTER  
4400 WEST 18th STREET • HOUSTON, TEXAS 77092-8501

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### Student Media Consent and Release Form

*Throughout the school year, students may be highlighted in efforts to promote HISD activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of our schools through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media.*

I, as the parent or guardian of \_\_\_\_\_, hereby give HISD and its employees, representatives, and authorized media organizations permission to print, photograph, and record my child for use in audio, video, film, or any other electronic, digital and printed media.

- a. This is with the understanding that neither HISD nor its representatives will reproduce said photograph, interview, or likeness for any commercial value or receive monetary gain for use of any reproduction/broadcast of said photograph or likeness. I am also fully aware that I will not receive monetary compensation for my child's participation.
- b. I further release and relieve HISD, its Board of Trustees, employees, and other representatives from any liabilities, known or unknown, arising out of the use of this material.

I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions.

**Please understand that failure to return this release form within ten (10) school days from the date of distribution will constitute approval of the above requests.**

**Please Print**

Name of child \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_ Phone Number \_\_\_\_\_

**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 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.

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Have you had a medical illness or injury since your last check up or physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. 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? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
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 channelopathy (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?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>	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:	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
7. 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"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Females Only</i>		
			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? _____		
			<i>Males Only</i>		
			20. Are you missing a testicle? _____		
			21. 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*
<b>MEDICAL</b>			
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.