

Dear Parents,

You may begin submitting forms for the **2026-2027** school year on **Monday April 27<sup>th</sup>**. Any forms submitted prior to April 27<sup>th</sup>, will have to be resubmitted.

**Athletic link to online paperwork is:** <https://katvisd.rankonesport.com/>

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

**Fine Arts link to online paperwork is:** <https://katvisd-finearts.rankonesport.com/>

**The physical form must be completed by a physician and dated after May 1<sup>st</sup>, 2026, to be valid for the 2026-2027 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 be allowed 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-phvsical-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/athletics/home/directory>

## Katy Independent School District Sponsored Physical 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.**

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.

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

<b>2026-2027</b>				
<b>ECG and Physical Schedule</b>				
<b><u>Date</u></b>	<b><u>Facility</u></b>	<b><u>Location</u></b>	<b><u>Physical Time</u></b>	<b><u>ECG Time</u></b>
Monday, May 4, 2026	CRHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Tuesday, May 5, 2026	MCHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Wednesday, May 6, 2026	SLHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Thursday, May 7, 2026	PHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Monday, May 11, 2026	MRHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Tuesday, May 12, 2026	OTHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Wednesday, May 13, 2026	THS	Gym 4	5:30pm-6:15pm	3:30pm - 5pm
Thursday, May 14, 2026	JHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Monday, May 18, 2026	FHS	Competition Gym	5:30-6:15pm	3:30pm - 5pm
Tuesday, May 19, 2026	KHS	Competition Gym	5:30pm-6:15pm	3:30pm - 5pm
Tuesday, July 21, 2026	OTHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Wednesday, July 22, 2026	JHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Thursday, July 23, 2026	KHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Monday, July 27, 2026	THS	Gym 4	5:30pm-6:15pm	*By Appt. Only
Tuesday, July 28, 2026	MCHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Wednesday, July 29, 2026	PHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Thursday, July 30, 2026	SLHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Monday, August 3, 2026	FHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Wednesday, August 5, 2026	MRHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Monday, August 10, 2026	CRHS	Competition Gym	5:30pm-6:15pm	*By Appt. Only
Thursday, August 13, 2026	Legacy	Community Room	5:30pm-6:15pm	*By Appt. Only
Friday, August 14, 2026	Legacy	Community Room	5:30pm-6:15pm	*By Appt. Only

\*Fall ECG sign up for by appointment only during the school day at your child's campus only: during the month of September

<https://www.signupgenius.com/go/70A0D49A5AE2BA2FD0-61186915-fall>

You may download a current blank physical or upload your completed physical for athletics at:  
[katyisd.rankonesport.com](http://katyisd.rankonesport.com)

**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 by Katy ISD for the sole purpose of clearing students for participation in extra-curricular/co-curricular 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

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.

<p>1. Have you had a medical illness or injury since your last check up or physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has any family member or relative died of heart problems or of sudden unexplained death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No                  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? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Has a physician ever denied or restricted your participation in activities for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, how many times? _____                  When was your last concussion? _____                  How severe was each one? (Explain below) _____                  Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If yes, check appropriate box and explain below:</p> <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
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<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle																	
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot																		

**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*
<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/