



TSSAA Preparticipation Medical Evaluation Form

PERSONAL HISTORY

Date _____ Time _____

Last Name

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First Name

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MI

Street _____ City _____
 Zip _____ Phone _____ Sex: M / F
 DOB _____ Age _____ SS# _____
 Father's Name _____
 Home # _____ Work # _____
 Mother's Name _____
 Home # _____ Work # _____
 Other Emergency Contact _____
 (relation) _____ Phone _____
 Family Physician _____
 Name of Personal Insurance _____

Upcoming Grade(circle) <7 7 8 9 10 11 12
School Name: _____
Sport(s) (check):
 Baseball Cheer Hockey Tennis
 Boys Basketball X-Country Boys Soccer Track
 Girls Basketball Football Girls Soccer Volleyball
 Bowling Golf Softball Wrestling
 Other:

Parents, please answer ALL questions. Explain "YES" answers (use additional sheet if necessary).

	YES	NO
1 Have you ever had a preparticipation physical before? (<input type="checkbox"/> check if by TSMO)	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you had any medical problems since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
3 Have you ever been hospitalized? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you have any allergies (to medications, foods, bees or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
5 Are you currently taking any medications and/or dietary supplements (creatine, vitamins, herbal supplements, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
6 Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you ever had chest pain, discomfort, or unexplained shortness of breath during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8 Do you tire during exercise more quickly than your friends?	<input type="checkbox"/>	<input type="checkbox"/>
9 Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
10 Have you ever been told that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
11 Has your heart ever raced or skipped beats?	<input type="checkbox"/>	<input type="checkbox"/>
12 Has any family member ever had a history of heart problems or of sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
13 Do you have any skin problems (itching, rashes, severe acne)?	<input type="checkbox"/>	<input type="checkbox"/>
14 Have you ever been knocked out or unconscious, lost your memory, had a head injury, or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
15 Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
16 Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
17 Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
18 Have you ever become dizzy, ill, or passed out from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
19 Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
20 Do you have asthma? (check <input type="checkbox"/> yes if you have an inhaler)	<input type="checkbox"/>	<input type="checkbox"/>
21 Do you have any special equipment (pads, sports braces, neck roll/collar, mouth guard, eye guard)?	<input type="checkbox"/>	<input type="checkbox"/>
22 Do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
23 Do you wear glasses, contacts, or protective eyewear? Eye Doctor _____	<input type="checkbox"/>	<input type="checkbox"/>
24 Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Elbow/Arm <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
25 Have you ever had any other medical problems (infectious mononucleosis, diabetes, viral infections)?	<input type="checkbox"/>	<input type="checkbox"/>
26 What year was your last tetanus shot? _____	<input type="checkbox"/>	<input type="checkbox"/>
27 When was your last measles immunization? _____	<input type="checkbox"/>	<input type="checkbox"/>
28 When were your first and last menstrual periods (month/year)? (Females) _____ / _____	<input type="checkbox"/>	<input type="checkbox"/>
29 What was the longest number of days between your periods last year? (Females) _____	<input type="checkbox"/>	<input type="checkbox"/>

LEGAL MEDICAL CONSENT and PRIVACY STATEMENT

I/We hereby give consent for (athlete's name) _____ to represent (name of school) _____ in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of rules injuries are still possible. On rare occasions these injuries can be severe and result in total disability, paralysis, or even death.

I/We further grant permission to the school, its physicians, and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the student athlete named above. I/We further release the school, its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept the responsibility for any and all damages or injuries sustained as a result of participation in the sports(s) named above.

By the execution of this consent, the student athlete named above and his/her parent(s)/guardian(s) do hereby consent to the screening, examination, and testing of the student athlete during the course of the preparticipation examination by those personnel performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the examination of the student athlete on the forms attached hereto by those practitioners performing the examination.

The student athlete named above and his/her parent(s)/guardian(s) do also hereby consent to the dissemination of the information compiled from the preparticipation evaluation to the health care practitioners providing the service related to the preparticipation examination, the student athlete's coach(es) and the appropriate representatives of the school. This examination is not intended to replace a complete annual physical, which is recommended to all adolescents and should not be viewed as a substitute. In addition, this exam is not intended to interfere with any parent/physician relationship that currently exists.

I/We hereby acknowledge that I/we have received and understand the Tennessee Sports Medicine & Orthopaedics Notice of Privacy Practices for sports medicine services, which can be found at www.tennesseesportsmed.com or 2005 Crossing Circle Mt. Juliet, TN 37122 615-553-5500.

 Student Signature (if 18 yrs or older)

(Please sign in BLUE or BLACK INK)

 Parent / Legal Guardian Signature

PHYSICAL EXAMINATION

Name _____ School _____ Sport _____

General:
 Height _____ in.
 Weight _____ lb.
 BP _____ / _____
 Heart Rate _____

Vision: (L) _____ (R) _____
 20/20 20/20
Other: _____
Corrected: Glasses Contacts
 Further evaluation recommended
 Further evaluation required for clearance
Eye professional: _____

For office use:
 Form screened
 M/S evaluation

Urine Sample:
 Taken Not Required
 Not Taken

Musculoskeletal Examination

Physician Notes

	WNL	See Flex Ed	See MD	Abnormal Findings	Presently under care	Requires further evaluation
Neck						
Shoulder / Arm						
Hip						
Knee						
Ankle						
Hamstring / Heel Cord						
Spine						

Medical Examination

Physician Notes

	WNL	Abnormal Findings	Presently under care	Requires further evaluation
Head, Eyes				
Ear, Nose, Throat				
Heart				
Chest, Lungs				
Skin, Lymphatics				
Abdomen, Hernia				
Genitalia (Males)				

CLEARED FOR PARTICIPATION

Cleared AFTER completing evaluation / rehabilitation for: _____

NOT CLEARED for _____ Reason: _____

Recommendations or Conditions for participation (inhaler, bracing, taping, rehab, etc.) _____

 Physician Printed Name or Code

 Physician Signature

 Date