2010-11 PRE-PARTICIPATION MEDICAL EVALUATION FORM

***Entire Page To Be Completed By Patient**

Personal History

Name ______ Sex ______ Age ______ DOB ______

Grade ______ Sport(s) ______

School ______

Personal Physician ______ Address ______ Telephone ______

Have you every had a pre-participation physical before? ___ Yes ___ No If yes, when/where ________________

Please explain "Yes" answers below.	**Yes**	**No**
1. Have you ever been hospitalized?	______	_____
2. Have you ever had surgery?	______	_____
3. Are you presently taking any medications or pills?	______	_____
4. Do you have allergies (medicine, bees or other stinging insects?	______	_____
5. Have you every passed out during exercise?	______	_____
6. Have you ever been dizzy during or after exercise?	______	_____
7. Have you ever had chest pain during exercise?	______	_____
8. Do you tire more quickly than your friends during exercise?	______	_____
9. Have you ever had high blood pressure?	______	_____
10. Have you ever been told that you have a heart murmur?	______	_____
11. Has anyone in your family died of heart problems or a sudden death before the age of 50?	______	_____
12. Do you have any skin problems (itching, rashes, acne)?	______	_____
13. Have you ever had a head injury?	______	_____
14. Have you ever been knocked unconscious?	______	_____
15. Have you ever had a seizure?	______	_____
16. Have you ever had a stinger, burner or pinched nerve?	______	_____
17. Have you ever had heat or muscle cramps?	______	_____
18. Have you ever been dizzy or passed out in the heat?	______	_____
19. Do you have trouble breathing or do you cough during or after activities?	______	_____
20. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)?	______	_____
21. Have you had any problems with your eyes or vision?	______	_____
22. Do you wear glasses or contacts or protective eye wear?	______	_____

23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?

______ Head	______ Shoulder	______ Thigh	______ Neck	______ Elbow
______ Knee	______ Chest	______ Forearm	______ Shin/Calf	______ Foot
______ Back	______ Wrist	______ Ankle	______ Hip	______ Hand

24. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	______	_____
25. Have you ever had a medical problem since your last evaluation?	______	_____

26. When was your last tetanus shot? ________________________________

27. When was your last measles shot? ________________________________

FEMALE ONLY

28. When was your first menstrual period? ________________________________

29. When was your last menstrual period? ________________________________

30. When was the longest time between your periods last year? ____________________

Please explain "yes" answers here:

I herby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete ______ Signature of Parent/Guardian ______ Date ______

Name: ______________________________ School: ______________________________

Information below is to be completed by medical staff only.

Height ____________ Weight ____________ BP ________/________ Pulse________

Vision R 20/_____ L 20/_____ Corrected? _____ Yes _____ No Pupils ________

Musculoskeletal Examination Examiner: ______________________________

Been to Physician in past 2 years for muscle, joint, or bone pain? ___ No ___ Yes: ________________

	Normal	Abnormal Findings
Neck/Back		
Upper Extremities		
Lower Extremities		
General Strength		
General Flexibility		

General Examination Examiner: ______________________________

	Normal	Abnormal Findings
Ears, Nose, Throat		
Heart		
Chest/Lungs		
Skin/Lymphatic		
Abdominal		
Genitalia/Hernia		

General Notes / Other:

Official Recommendation

A. This athlete _____ **may** _____ **may not** compete in athletics based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is **recommended** / **required** :

C. Recommend further consultation with ____

TSSAA Approved Examiner: (Print) ______________________ (Sign) ______________________ Date: __________

TSSAA PRE-PARTICIPATION EVALUATION **CLEARANCE FORM**

NAME: ____________________ SEX: ________ AGE: ________ DATE OF BIRTH: ____________

GRADE: _______ SCHOOL: ____________________

_______ Cleared without restriction

_______ Cleared, with recommendations for further evaluation or treatment for: ____________________

____

____

____

_______ Not cleared for ________ All sports ___________ Certain Sports: ____________ Reason: ______________

Recommendations: ____________________

____

EMERGENCY INFORMATION

Allergies: ____________________

Other Information: ____________________

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

_______ Up to date (see attached documentation) ________ Not up to date Specify ____________________

Name of physician (print/type): ____________________ **Date:**____________________

Address:____________________ **Phone:**____________________

Signature of TSSAA Approved Examiner:____________________

Adapted from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedeic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.

TSSAA PRE-PARTICIPATION EVALUATION **CLEARANCE FORM**

NAME: ____________________ SEX: ________ AGE: ________ DATE OF BIRTH: ____________

GRADE: _______ SCHOOL: ____________________

_______ Cleared without restriction

_______ Cleared, with recommendations for further evaluation or treatment for: ____________________

____

____

____

_______ Not cleared for ________ All sports ___________ Certain Sports: ____________ Reason: ______________

Recommendations: ____________________

____

EMERGENCY INFORMATION

Allergies: ____________________

Other Information: ____________________

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

_______ Up to date (see attached documentation) ________ Not up to date Specify ____________________

Name of physician (print/type): ____________________ **Date:**____________________

Address:____________________ **Phone:**____________________

Signature of TSSAA Approved Examiner:____________________

Adapted from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedeic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.

I. EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name: ______________________________ Sport: ___________________________ Sex: M _____ F _____

Grade: __________ Age: __________ Date of Birth: _____/_____/_____

Parent's Name: ____

Work Address: ____

Phone Number: ____________________________

Home Address: ____

Phone Number: ____________________________

Another Person to Contact: ____

Relationship: ___________________________ Phone Number: _________________________

Insurance Name: ____

Policy and Group Numbers: ____

ALLERGIES: ____

Consent Statement: Authorizing Treatment

Parent's Signature: ____

Student's Signature (if over age 18): ____

II. PARENT'S CONSENT

I herby give my consent for ____ to represent
(Name of Student)

______________________________________ in the sport of _______________________________.
(Name of School)

Date: ___________________________ Signature: ____________________________________

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