2009-10 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: _____