TSSAA PREPARTICIPATION EVALUATION HISTORY FORM

DATE OF EXAM:

NAME: SEX: AGE: DATE OF BIRTH:

GRADE: SCHOOL: SPORT(S):

HOME ADDRESS: HOME PHONE:

PERSONAL PHYSICIAN: EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

1. Has a doctor ever denied or restricted your participation in sports for any reason? ..... Y N

2. Do you have an ongoing medical condition (like diabetes or asthma)? ..... Y N

3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ..... Y N

4. Do you have allergies to medicines, pollens, foods, or stinging insects? ..... Y N

5. Have you ever passed out or nearly passed out DURING exercise? ..... Y N

6. Have you ever passed out or nearly passed out AFTER exercise? ..... Y N

7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ..... Y N

8. Does your heart race or skip beats during exercise?..... Y N

9. Has a doctor ever told you that you have:

High Blood Pressure ..... Y N
High Cholesterol ..... Y N A
heart murmur ..... Y N A
heart infection..... Y N

10. Has a doctor ever ordered a test for your heart?
(for example, ECG, echocardiogram) ..... Y N

11. Has anyone in your family died for no apparent reason? ..... Y N

12. Does anyone in your family have a heart problem?..... Y N

13. Has any family member or relative died of heart problems or of sudden death before age 50? ..... Y N

14. Does anyone in your family have Marfan Syndrome?..... Y N

15. Have you ever spent the night in a hospital? ..... Y N

16. Have you ever had surgery?..... Y N

Have you every had an injury, like a sprain, muscle or nent tear, or tendonitis, that caused you to miss a practice or game?..... Y N

If Yes,
explain:_____

Have you had any broken or fractured bones or cated joints?..... Y N

If Yes,
explain:_____

Have you ever had a bone or joint injury that required x-rays, , CT, surgery, injections, rehabilitation, physical therapy, a brace, st, or crutches? ..... Y N

If Yes,
explain:_____

Have you ever had a stress fracture? ..... Y N

Have you been told that you have or have had

x-ray for atlantoaxial (neck) instability?..... Y N

Do you regularly use a brace or assistive device?..... Y N

23. Has a doctor ever told you that you have asthma or allergies? ..... Y N

24. Do you cough, wheeze or have difficulty breathing during or after exercise?..... Y N

25. Is there anyone in your family who has asthma? ..... Y N

26. Have you ever used an inhaler or taken asthma medicine? ..... Y N

27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?..... Y N

28. Have you had infectious mononucleosis (mono) within the last month?..... Y N

29. Do you have rashes, pressure sores, or other skin problems? ..... Y N

30. Have you ever had a herpes skin infection? ..... Y N

31. Have you ever had a head injury or concussion? ..... Y N

32. Have you been hit in the head and been confused or lost your memory? ..... Y N

33. Have you ever had a seizure? ..... Y N

34. Do you have headaches with exercise? ..... Y N

35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? ..... Y N

36. Have you ever been unable to move your arms or legs after being hit of falling?..... Y N

37. When exercising in the heat, do you have severe muscle cramps or become ill?..... Y N

38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?..... Y N

39. Have you had any problems with your eyes or vision? ..... Y N

40. Do you wear glasses or contact lenses? ..... Y N

41. Do you wear protective eyewear, such as goggles or a face shield?..... Y N

42. Are you happy with your weight?..... Y N

43. Are you trying to gain or lose weight?..... Y N

44. Has anyone recommended you change your weight or eating habits?..... Y N

45. Do you limit or carefully control what you eat?..... Y N

46. Do you have any concerns that you would like to discuss with a doctor?..... Y N **FEMALES ONLY 47.** Have you ever had a menstrual period? ..... Y N

48. How old were you when you had your first menstrual period? ___

49. How many periods have you had in the last 12 Months? _____

Explain "Yes" answers here: _____
_____
_____
_____

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

Athlete's Signature: Parent/Guardian Signature: Date:

Questions taken 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 PREPARTICIPATION EVALUATION PHYSICAL EXAMINATION FORM

NAME: DATE OF BIRTH: SCHOOL:

HEIGHT: WEIGHT: % BODY FAT (OPT.):

PULSE: BP: _____/_____ (_____/_____ , _____/_____)

VISION R 20/ L 20/ CORRECTED: Y N PUPILS: EQUAL UNEQUAL

Follow-Up Questions on More Sensitive Issues 1. Do you feel stressed out or under a lot of pressure?..... Y N

2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?..... Y N

3. Do you feel safe?..... Y N

4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? ..... Y N

5. During the past 30 days, did you use chewing tobacco, snuff, or dip?..... Y N

6. During the past 30 days, have you had at least 1 drink of alcohol? ..... Y N

7. Have you ever taken steroid pills or shots without a doctor's prescription?..... Y N

8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?..... Y N

9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc..... Y N

Notes
:

NORMAL ABNORMAL FINDINGS INITIALS* MEDICAL Appearance
Eyes/ears/nose/throat Hearing Lymph nodes Heart Murmurs Pulses Lungs Abdomen Genitourinary (males only)** Skin **MUSCULOSKELETAL** Neck Back Shoulder/arm Elbow/forearm Wrist/hand/fingers Hip/thigh Knee Leg/ankle Foot/Toes

*Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

Notes
:

Name of physician (print/type): Date:

Address: Phone:

Signature of physician: , **MD or DO**

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TSSAA PREPARTICIPATION 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 physician: , **MD or DO**

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.

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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: _____

MED-02