**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Date of birth</th>
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<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
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### Medicines and Allergies

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

### BONE AND JOINT QUESTIONS

1. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?

2. Have you ever had any broken or fractured bones or dislocated joints?

3. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

4. Have you ever had a stress fracture?

5. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

6. Do you regularly use a brace, orthotics, or other assistive device?

7. Do you have a bone, muscle, or joint injury that bothers you?

8. Do any of your joints become painful, swollen, feel warm, or look red?

9. Have you ever had any broken or fractured bones or dislocated joints?

10. Have you ever had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

11. Do you regularly use a brace, orthotics, or other assistive device?

12. Do you have a bone, muscle, or joint injury that bothers you?

13. Do any of your joints become painful, swollen, feel warm, or look red?

### HEART HEALTH QUESTIONS ABOUT YOU

1. Have you ever had a heart attack?

2. Have you ever been told you have any heart problems? If so, check all that apply:
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection
   - Kawasaki disease
   - Other:

3. Has a doctor ever ordered a test for your heart? (For example, ECG/EGK, echocardiogram)

4. Do you get lightheaded or feel more short of breath than expected during exercise?

5. Have you ever had an unexplained seizure?

6. Do you get more tired or short of breath more quickly than your friends during exercise?

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

1. Has any family member or relative died of heart problems or had an echocardiogram?

2. Have you or anyone in your family had heart problems, a pacemaker, or a heart transplant?

3. Have you or anyone in your family had heart problems, a pacemaker, or a heart transplant?

4. Has anyone in your family been told they have any heart problems?

5. Has anyone in your family been told they have any heart problems?

### MEDICAL QUESTIONS

1. Have you ever used an inhaler or taken asthma medicine?

2. Have you ever used an inhaler or taken asthma medicine?

3. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

4. Have you ever had a heart attack?

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### FEMALES ONLY

1. Have you ever had a menstrual period?

2. Have you ever had a menstrual period?

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25. Have you ever had a menstrual period?

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

Signature of athlete | Signature of parent/guardian | Date
---|---|---

THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________________________________________________
Name ____________________________________________________________
Date of birth ____________________________
Sex _______ Age _______ Grade _______ School ________________________________
Sport(s) ____________________________________________________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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6. Do you regularly use a brace, assistive device, or prosthetic?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteopenia or osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

Explain “yes” answers here

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

Signature of athlete __________________________________________
Signature of parent/guardian ______________________________________
Date _______________
## Preparticipation Physical Evaluation

### PHYSICAL EXAMINATION FORM

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

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<tr>
<th>Height</th>
<th>Weight</th>
<th>☐ Male</th>
<th>☐ Female</th>
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<tbody>
<tr>
<td>BP / ( / )</td>
<td>Pulse</td>
<td>Vision R 20/</td>
<td>L 20/</td>
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#### MEDICAL

**NORMAL** | **ABNORMAL FINDINGS**
---|---
Appearance
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
- Pupils equal
- Hearing

Lymph nodes

Heart
- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

Pulses
- Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only)

Skin
- HSV, lesions suggestive of MRSA, line corporis

Neurologic

### MUSCULOSKELETAL

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/ankle
- Foot/toes
- Functional
  - Duck-walk, single leg hop

< Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

* Consider (O) exam if in private setting. Having third party present is recommended.

* Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☑ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared
- Pending further evaluation
- For any sports
- For certain sports

Reason

Recommendsion

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________ Date ___________
Address ____________________________________________________________________________ Phone ___________
Signature of physician __________________________________________________________________ MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

This form is for summary use in lieu of the physical exam form and health history form and may be used when HIPAA concerns are present.

Name ____________________________  Sex □ M □ F  Age __________  Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason ______________________________

Recommendations ____________________________________________

______________________________________________________________________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________________________________________  Date __________

Address __________________________________________  Phone _________________________

Signature of physician __________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies __________________________________________

______________________________________________________________________________________________________________________________

Other information __________________________________________

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CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE
*Entire Page Completed By Patient

Athlete Information

Last Name______________________________ First Name______________________________ MI ______
Sex: [ ] Male [ ] Female Grade ____________ Age ________ DOB ___/___/______
Allergies________________________________________________________________________
Medications_______________________________________________________________________
Insurance________________________________________________________________________ Policy Number ________________________________
Group Number ________________________________ Insurance Phone Number __________________

Emergency Contact Information

Home Address ___________________________________________ (City) ____________________ (Zip) ____________
Home Phone __________________ Mother’s Cell _______________ Father’s Cell __________________
Mother’s Name ___________________________________________ Work Phone _______________________
Father’s Name ___________________________________________ Work Phone _______________________
Another Person to Contact ___________________________________________________________
Phone Number ___________________________ Relationship _______________________________

Legal/Parent Consent

I/We hereby give consent for (athlete’s name) ________________________________ to represent (name of school) ___________________________ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those 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 student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.

Signature of Athlete ________________________________ Signature of Parent/Guardian ___________________________ Date __________________________