TMA/TSSAA Preparticipation Medical Evaluation Form

This page to be filled out completely by the student-athlete and their parent or guardian.

Name: _____ Sex:❒ M ❒ F Age:____ Date of Birth:_____

Grade: 9 10 11 12 School:_____ Sport: _____

Home Address:_____

City:_____ State:_____ Zip:_____

Father's Name: _____ Home Phone:_____ Work Phone:_____

Mother's Name: _____ Home Phone:_____ Work Phone:_____

Another Person to contact: _____Relationship: _____Phone#_____

Personal Physician:_____ Health Insurance Name: _____

Have you ever had a pre-participation physical before? ❒Yes ❒No

If so, when/where?_____

Please explain Yes answers below. **If the questions do not pertain to you , simply ignore them.**

		Yes	No
1.	Have you ever been hospitalized?	❒	❒
	Have you ever had surgery?	❒	❒
2.	Are you presently taking any medication or pills?	❒	❒
3.	Do you have any allergies (medicine, bees, or other stinging insects)?	❒	❒
4.	Have you ever passed out during exercise?	❒	❒
	Have you ever been dizzy during or after exercise?	❒	❒
	Have you ever had chest pain during or after exercise?	❒	❒
	Do you tire more quickly than your friends during exercise?	❒	❒
	Have you ever had high blood pressure?	❒	❒
	Have you ever been told that you have a heart murmur?	❒	❒
	Have you ever had a racing of your heart or skipped heartbeats?	❒	❒
	Has anyone in your family died of heart problems or a sudden death before the age of 50	❒	❒
5.	Do you have any skin problems (itching, rash, acne)?	❒	❒
6.	Have you ever had a head injury?	❒	❒
	Have you ever been knocked out or unconscious?	❒	❒
	Have you ever had a seizure?	❒	❒
	Have you ever had a "stinger", "burner", or pinched nerve?	❒	❒
7.	Have you ever had heat or muscle cramps?	❒	❒
8.	Do you have trouble breathing or do you cough during or after activities?	❒	❒
9.	Do you use any special equipment (pads, braces, neck roll, mouth guard, eye guard)?	❒	❒
10.	Have you had any problems with your eyes or vision?	❒	❒
	Do you wear glasses or contacts or protective eye wear?	❒	❒
11.	Have you ever had any other medical problems (such as infectious mononucleosis, diabetes)?	❒	❒
12.	Have you had any medical problem since your last evaluation?	❒	❒
13.	Have you ever sprained/strained, dislocated, broken, or had repeated swelling of any bones or joints?	❒	❒

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

14. When was your last tetanus shot?_____
    When was your last measles immunization?_____
15. Females only:
    When was your first menstrual period?_____ Your last period?_____
    What was the longest time between your periods last year?_____

Please explain yes answers here:

To the best of my knowledge, my answers to the above questions are correct. As parent/guardian of the student-athlete whose name appears at the top of this page and whose signature is found below, I recognize the potential dangers inherent to interscholastic athletics and give my permission for full participation. In the event of an emergency, I herein give my permission for treatment by any qualified health care practitioner and that the information contained in this form can be released to any physician or health care facility administering emergency care and to representatives of Blount Memorial Total Rehabilitation/Maryville Orthopedic Clinic to discuss these matters with the athlete's coach.

Signature of Parent/Guardian _____ Date _____ Signature of Athlete _____ Date _____

TMA/TSSAA PREPARTICIPATION MEDICAL EVALUATION FORM

This page to be completed by appropriate medical personnel.

BP:_____/_____ **PR:_____** **UA: Sugar/_____Protein/_____Blood/_____**

Height:_____ '_____" **Weight:_____lbs.**

Vision: Right20/_____ Left 20/_____ **Corrected?** ❒ **Yes** ❒ **No**

	WNL	Comments/Abnormal Findings	Needs Referral or Follow-up	Examiner
1. **Auscultation** **Heart** **Lungs**				
2. **Orthopedic** **Shoulders** **Neck** **Back** **Knees** **Ankles**				
3. **Palpation** **Neck** **Abdomen** **Genitalia**				
4. **ENT** **Eyes** **-pupils** **Nose** **Throat**				
5. **General Medical** **Skin** **Med Screen**				

Flexibility	Hypomobile		Normal		Hypermobile	Needs Attention	**Comments**	Examiner
Rotator Cuff	1	2	3	4	5			
Neck	1	2	3	4	5			
Back	1	2	3	4	5			
Hips	1	2	3	4	5			
Hamstrings	1	2	3	4	5			
Achilles	1	2	3	4	5			

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:

_____

C. Recommend further consultation with _____

Signature of physician_____ **Date:**_____