



PREPARTICIPATION PHYSICAL EVALUATION

Please Print

Today's Date _____

Name (Last name first) _____ Date of Birth _____ Sex: Male ___ Female ___

School _____ Sport(s) _____

DO NOT WRITE IN THE AREA BELOW! Please complete bottom & back of form.

Complete	General Exam	Height _____ Weight _____ BP _____ / _____ Pulse _____		Regular Pulse Rate: Y N	
		Vision: R20/ _____ L20/ _____ Corrected: Y N Pupils: Equal Unequal			
			Normal	Abnormal Findings	Signature
	Orthopaedic Exam	Ear, Nose, Throat			
		Heart (Auscultate in Supine & Standing)			
		Chest/Lungs			
		Skin/Lymphatics			
		Abdominal			
		Genitalia/Hernia			
		Neck			
		Shoulder			
		Elbow			
		Wrist			
		Hand			
		Back			
Knee					
Ankle					
Foot					
Flexibility					

Clearance

A. Cleared B. Cleared after completing evaluation/rehabilitation for _____

C. Not cleared for Collision Contact Non-Contact ___ Strenuous ___ Moderately Strenuous ___ Non-Strenuous

Due to: _____

Recommendations: _____

Physician Signature: _____ Date: _____

EMERGENCY INFORMATION

(Please print) Student's name _____ Parents' Names _____

Student's Home Address _____ City _____ Zip _____

Father's SS# _____ Mother's SS# _____

Parent's Work Phone _____ Primary Care Physician _____

Another Person to Contact _____ Relationship _____ Phone _____

Insurance name _____ Policy & Group Numbers _____

HEALTH HISTORY

To be filled out by student and/or parents

Explain "Yes" answers below:

	YES	NO
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies (medicine, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever experience excessive, unexpected or unexplained shortness of breath or fatigue associated with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan's syndrome or clinically important arrhythmias?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any skin problems (itching rashes, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble breathing, do you experience wheezing or do you cough during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?		
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest		
<input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand <input type="checkbox"/> Foot		
12. Have you ever had any other medical problems (infectious mononucleosis, diabetes, etc.)?		
13. Have you had a medical problem or injury since your last evaluation?		
14. When was your last tetanus shot? _____ When was your last measles immunization? _____		
15. Female Athletes: When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____		

Explain "Yes" answers: _____

MEDICAL CONSENT & WAIVER

Students may not participate in school sports without properly signed consent.

I/We hereby state that, to the best of my knowledge, the answers to the above questions are correct. I/We understand that these limited medical examinations are required by TSSAA before students may participate in school athletic programs. I/We further understand these are screenings only and a physician should further evaluate any medical concern as a result of these screenings. I/We hereby release The Bone & Joint Clinic, STAR Physical Therapy, and all other participants providing these examinations from any liability which may arise from them. I/We hereby grant permission to _____ School, its physicians and/or Trainers to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the above individual. I/We further authorize the Athletic Trainers at the above-named institution who are under the direction and guidance of a physician to render any first aid or preventive, rehabilitative or emergency treatment deemed reasonably necessary to protect the health and well being of the above individual. I/We additionally grant, when necessary for protecting the health and well being of the above individual, permission for hospitalization, treatment or surgery at a competent and/or accredited facility. I/We further release _____ School, its Trainers, agents, servants and employees from any liability for damage and injury to the above individual and hereby accept the full responsibility for any and all damages or injuries sustained as a result of participation in _____ (Sport or extracurricular activity).

Print Student Name _____

Student signature _____ Parent/Guardian(s) signature _____ Date _____

Coach signature _____ School _____ Date _____