

TMA/TSSAA PREPARTICIPATION MEDICAL EVALUATION FORM

Personal History

Name	Sex	Age	DOB
Grade	Sport(s)		
School			

Personal Physician	Address	Telephone
Have you every had a preparticipation physical before? ___ Yes ___ No If yes, when/where _____		

Please explain "Yes" answers below.

	Yes	No
1. Have you ever been hospitalized? Have you ever had surgery?	_____	_____
2. Are you presently taking any medications or pills?	_____	_____
3. Do you have allergies (medicine, bees or other stinging insects)?	_____	_____
4. Have you every passed out during exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during 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? 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, rashes, acne)?	_____	_____
6. Have you ever had a head injury? Have you ever been knocked unconscious? Have you ever had a seizure? Have you ever had a stinger, burnner or pinched nerve?	_____	_____
7. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	_____	_____
8. Do you have trouble breathing or do you cough during or after activities?	_____	_____
9. Do you use any special equipment (pads, braces, neck role, 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 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	_____	_____
12. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	_____	_____
13. Have you ever had a medical problem since your last evaluation?	_____	_____
14. When was your last tetanus shot? _____ When was your last measles shot? _____		
15. When was your first menstrual period? _____ When was your last menstrual period? _____ 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
Signature of Coach	School	

General Physical Education

Examiner: _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/____ L 20/____ Corrected? ____ Yes ____ No Pupils _____

	Normal	Abnormal Findings
Ears, Nose, Throat	_____	_____
Heart	_____	_____
Chest/Lungs	_____	_____
Skin/Lymphatic	_____	_____
Abdominal	_____	_____
Genitalia/Hernia	_____	_____

Musculoskeletal Examination

Examiner: _____

	Normal	Abnormal Findings
Neck/Back	_____	_____
Upper Extremities	_____	_____
Lower Extremities	_____	_____
Flexibility	_____	_____

Optional Lab

Urine Sugar _____

Urine Protein _____

Urine Hematest _____

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: _____

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: _____

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

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 hereby give my consent for _____ to represent
(Name of Student)
_____ in the sport of _____.
(Name of School)

Date: _____ Signature: _____