

Physicals are valid for one year and must be signed/dated after May 31, 2010.



**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.**

<b>General Exam</b>	Height _____ Weight _____ BP _____ / _____ Pulse _____	Nurse Initials: _____		
	Vision: R 20/ _____ L 20/ _____	Corrected: Y N Pupils: Equal Unequal		
		Normal	Abnormal Findings	Signature
	Ear, Nose, Throat			
	Heart			
	Chest/Lungs			
	Skin/Lymphatics			
	Abdominal			
	Genitalia/Hernia			
	(Optional Labs)			
<b>Orthopaedic Exam</b>	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 Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Father's SS# \_\_\_\_\_ Mother's SS# \_\_\_\_\_

Parent 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 tire more quickly than your friends during 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"/>
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 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 had any other medical problems (infectious mononucleosis, diabetes, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had a medical problems or injury since your last evaluation? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. When was your last tetanus shot? _____ When was your last measles immunization? _____		
15 <b>Female Athletes:</b> 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