

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you presently taking any medication 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 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?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any skin problems (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble breathing or do you cough during or after activities?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment (pads, braces, neck roll, mouth guard, eye guard)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any other medical problems (such as infectious mononucleosis, diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any medical problem since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever sprained/strained, dislocated, broken, or had repeated swelling 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"/>	<input type="checkbox"/>
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: Right 20/ _____ 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
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Rotator Cuff	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Neck	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Back	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Hips	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Hamstrings	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5			
Achilles	1	2	3	4	5	1	2	3	4	5	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: _____