

TSSAA PREPARTICIPATION EVALUATION

HISTORY FORM

DATE OF EXAM: _____

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

GRADE: _____ SCHOOL: _____ SPORT(S): _____

HOME ADDRESS: _____ HOME PHONE: _____

PERSONAL PHYSICIAN: _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

- | | |
|---|--|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? Y N</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? Y N</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y N</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y N</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? Y N</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? Y N</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N</p> <p>8. Does your heart race or skip beats during exercise? Y N</p> <p>9. Has a doctor ever told you that you have:
High Blood Pressure Y N
High Cholesterol Y N
A heart murmur Y N
A heart infection Y N</p> <p>10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Y N</p> <p>11. Has anyone in your family died for no apparent reason? Y N</p> <p>12. Does anyone in your family have a heart problem? Y N</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? Y N</p> <p>14. Does anyone in your family have Marfan Syndrome? Y N</p> <p>15. Have you ever spent the night in a hospital? Y N</p> <p>16. Have you ever had surgery? Y N</p> <p>17. Have you every had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? Y N
If Yes, explain: _____</p> <p>18. Have you had any broken or fractured bones or dislocated joints? Y N
If Yes, explain: _____</p> <p>19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y N
If Yes, explain: _____</p> <p>20. Have you ever had a stress fracture? Y N</p> <p>21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? Y N</p> <p>22. Do you regularly use a brace or assistive device? Y N</p> | <p>23. Has a doctor ever told you that you have asthma or allergies? Y N</p> <p>24. Do you cough, wheeze or have difficulty breathing during or after exercise? Y N</p> <p>25. Is there anyone in your family who has asthma? Y N</p> <p>26. Have you ever used an inhaler or taken asthma medicine? Y N</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? Y N</p> <p>29. Do you have rashes, pressure sores, or other skin problems? Y N</p> <p>30. Have you ever had a herpes skin infection? Y N</p> <p>31. Have you ever had a head injury or concussion? Y N</p> <p>32. Have you been hit in the head and been confused or lost your memory? Y N</p> <p>33. Have you ever had a seizure? Y N</p> <p>34. Do you have headaches with exercise? Y N</p> <p>35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? Y N</p> <p>36. Have you ever been unable to move your arms or legs after being hit of falling? Y N</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? Y N</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N</p> <p>39. Have you had any problems with your eyes or vision? Y N</p> <p>40. Do you wear glasses or contact lenses? Y N</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? Y N</p> <p>42. Are you happy with your weight? Y N</p> <p>43. Are you trying to gain or lose weight? Y N</p> <p>44. Has anyone recommended you change your weight or eating habits? Y N</p> <p>45. Do you limit or carefully control what you eat? Y N</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? Y N</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? Y N</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 Months? _____</p> <p>Explain "Yes" answers here: _____

_____</p> |
|---|--|

I herby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: _____ Parent/Guardian Signature: _____ Date: _____

TSSAA PREPARTICIPATION EVALUATION

PHYSICAL EXAMINATION FORM

NAME: _____ DATE OF BIRTH: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT (OPT.): _____

PULSE: _____ BP: _____ / _____ (_____ / _____ , _____ / _____)

VISION R 20/ _____ L 20/ _____ CORRECTED: Y N PUPILS: EQUAL _____ UNEQUAL _____

Follow-Up Questions on More Sensitive Issues

1. Do you feel stressed out or under a lot of pressure?..... Y N
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?..... Y N
3. Do you feel safe? Y N
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? Y N
5. During the past 30 days, did you use chewing tobacco, snuff, or dip? Y N
6. During the past 30 days, have you had at least 1 drink of alcohol? Y N
7. Have you ever taken steroid pills or shots without a doctor's prescription? Y N
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? Y N
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. Y N

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			

*Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD or DO

TSSAA PREPARTICIPATION EVALUATION

CLEARANCE FORM

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

GRADE: _____ SCHOOL: _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for: _____

_____ Not cleared for _____ All sports _____ Certain Sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

_____ Up to date (see attached documentation) _____ Not up to date Specify _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD or DO

Adapted from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.

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Signature of physician: _____, MD or DO

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