PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: ___________________________ Date of birth: _______________________

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATION

Height: ___________________________ Weight: ___________________________

BP: ___________________________ Pulse: ___________________________

Vision: R 20/ ___________________________ L 20/ ___________________________

Corrected: □ Y □ N

MEDICAL

Appearance
   - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

Eyes, ears, nose, and throat
   - Pupils equal
   - Hearing

Lymph nodes

Heart
   - Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

Lungs

Abdomen

Skin
   - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

Neurological

MUSCULOSKELETAL

Neck

Back

Shoulder and arm

Elbow and forearm

Wrist, hand, and fingers

Hip and thigh

Knee

Leg and ankle

Foot and toes

Functional
   - Double-leg squat test, single-leg squat test, and box drop or step drop test

" Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): ___________________________ Address: ___________________________

Phone: ___________________________ Signature of health care professional: ___________________________

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ___________________________ Date of birth: ___________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ___________________________

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): ___________________________ Date: ___________________________

Address: ___________________________ Phone: ___________________________

Signature of health care professional: ___________________________ MD, DO, NP, or PA

SHARE EMERGENCY INFORMATION

Allergies: ___________________________

Medications: ___________________________

Other information: ___________________________

Emergency contacts: ___________________________

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ___________________________ Date of birth: ________________________________

Date of examination: _______________ Sport(s): ___________________________________

List past and current medical conditions. ___________________________________________

Have you ever had surgery? If yes, list all past surgical procedures. ___________________ 

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). ____________________________________________

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _______________________________________________________

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

Feeling nervous, anxious, or on edge

Not at all Several days Over half the days Nearly every day

0 1 2 3

Not being able to stop or control worrying

0 1 2 3

Little interest or pleasure in doing things

0 1 2 3

Feeling down, depressed, or hopeless

0 1 2 3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer)

Yes No

1. Do you have any concerns that you would like to discuss with your provider?

2. Has a provider ever denied or restricted your participation in sports for any reason?

3. Do you have any ongoing medical issues or recent illness?

HEART HEALTH QUESTIONS ABOUT YOU

Yes No

4. Have you ever passed out or nearly passed out during or after exercise?

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?

7. Has a doctor ever told you that you have any heart problems?

8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

Yes No

9. Do you get light-headed or feel shorter of breath than your friends during exercise?

10. Have you ever had a seizure?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

Yes No

11. Has any family member or relative died of heart problems? For example, drowning or an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?

12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?

13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
<table>
<thead>
<tr>
<th>BONE AND JOINT QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have a bone, muscle, ligament, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you missing a kidney, an eye, a testicle (moles), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you or does someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have you ever had or do you have any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL QUESTIONS (CONTINUED)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are you on a special diet or do you avoid certain types of foods or food groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEMALES ONLY</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Have you ever had a menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. When was your most recent menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. How many periods have you had in the past 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: ____________________________

Signature of parent or guardian: ____________________________

Date: ____________________________
CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE
*Entire Page Completed By Patient

Athlete Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex:</th>
<th>[ ] Male</th>
<th>[ ] Female</th>
<th>Grade</th>
<th>Age</th>
<th>DOB</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

Allergies

Medications

Insurance Policy Number

Group Number Insurance Phone Number

Emergency Contact Information

<table>
<thead>
<tr>
<th>Home Address</th>
<th>(City)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Mother's Cell</th>
<th>Father's Cell</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother's Name</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Father's Name</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

Another Person to Contact

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Relationship</th>
</tr>
</thead>
</table>

Legal/Parent Consent

I/We hereby give consent for (athlete's name) to represent (name of school) in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.

Signature of Athlete | Signature of Parent/Guardian | Date
**Student-athlete & Parent/Legal Guardian Concussion Statement**

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

**Student-Athlete Name:**

**Parent/Legal Guardian Name(s):**

After reading the information sheet, I am aware of the following information:

<table>
<thead>
<tr>
<th>Student-Athlete initials</th>
<th>Parent/Legal Guardian initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.</td>
<td></td>
</tr>
<tr>
<td>A concussion cannot be “seen.” Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.</td>
<td></td>
</tr>
<tr>
<td>I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.</td>
<td>N/A</td>
</tr>
<tr>
<td>I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.</td>
<td>N/A</td>
</tr>
<tr>
<td>I will/my child will need written permission from a <strong>health care provider</strong>* to return to play or practice after a concussion.</td>
<td></td>
</tr>
<tr>
<td>Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.</td>
<td></td>
</tr>
<tr>
<td>After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.</td>
<td></td>
</tr>
<tr>
<td>After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.</td>
<td></td>
</tr>
<tr>
<td>Sometimes repeat concussion can cause serious and long-lasting problems and even death.</td>
<td></td>
</tr>
<tr>
<td>I have read the concussion symptoms on the Concussion Information Sheet.</td>
<td></td>
</tr>
</tbody>
</table>

* **Health care provider** means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

---

**Signature of Student-Athlete**

**Date**

**Signature of Parent/Legal guardian**

**Date**
Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs
Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?
Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn’t just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete’s SCA will likely result from an inherited condition, while an adult’s SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart’s electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?
SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act
The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013
• The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  (i) Unexplained shortness of breath;
  (ii) Chest pains;
  (iii) Dizziness
  (iv) Racing heart rate; or
  (v) Extreme fatigue; and

• Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

• Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

__________________________
Signature of Student-Athlete  Print Student-Athlete’s Name Date

__________________________
Signature of Parent/Guardian  Print Parent/Guardian’s Name  Date