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.

		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 ever passed out during exercise?	
	Have you ever been dizzy during or after exercise?	
	Have you ever had chest pain/discomfort during exercise?	
	Have you had excessive, unexpected or unexplained shortness of breath 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?	
	Has anyone in your family developed a disability from heart disease 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, burner 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.	Have you lost/gained more than 15 lbs over the last 6 months?	
15.	When was your last tetanus shot? _____	
	When was your last measles shot? _____	
16.	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 hereby state that, to the best of my knowledge, my answers to the above questions are correct, and with my signature give Campbell Clinic permission to perform pre-participation physical on my child.

Signature of Athlete	Signature of Parent/Guardian	Date

Signature of Coach	School

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.
- 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
(v) Extreme fatigue

- 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

Campbell Clinic®
SPORTS MEDICINE

Campbell Clinic Concussion Policy for High School Athletes

Concussion is a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces. Several common characteristics:

- Headache
- Cognitive impairment
- Emotional liability
- Dizziness
- Blurred vision
- Loss of consciousness or amnesia
- Sleep disturbances- tired
- Sensitive to light and sound
- Nausea

New guidelines and best practice suggestions were discussed in Zurich in 2012, and many organizations including the NCAA and TSSAA have developed some new policies in reaction to the Zurich conference. Some important conclusions included that there should be no same day return to play with the diagnosis of concussion and that treatment of athletes <18 should be more conservative than that of adult athletes.

Ideally, neuropsychological testing (ie. Impact, SCAT2) plays an important role in concussion management; however at the high school level most schools do not have access to this type of testing.

The TSSAA has developed a policy for officials mandating that they remove any player exhibiting signs of concussion from play. That player cannot return to play the same day unless they are evaluated by a physician who must fill out and sign a "TSSAA Concussion Return to Play" form.

Our policy:

1. No same day return to play with the diagnosis of concussion.
2. Every athlete experiencing a concussion needs to be evaluated by a member of the sports medicine team as soon as possible. (ATC or physician if available)
3. Appropriate same day management should then be determined. (assess the need to go to the ER, handout with signs to look out for)
4. There may be a time of rest necessary before return to activity that can include both physical and mental rest.
5. Once asymptomatic a decision should then be made among the sports medicine team when the athlete can begin the graduated return to play protocol below. (Preferably there would be 24 hours between each step)

    a) No activity until asymptomatic.

    b) Low impact activity x 10 mins; Rest 20 mins; Repeat if asymptomatic Aerobic activity: 1 40 yd sprint followed by 10 jumping jacks / squats / situps / pushups; Rest 30 mins; Repeat if asymptomatic. Allowed to participate in lifting exercises w/ team.

    c) Sport- Specific Non-Contact drills: Running through plays / agility bag work etc

    d) Full Contact drills: ie. Sled blocking, pad blocking / tackling, one-on-one drills

    e) Return to game/play.

6. Every athlete diagnosed with a concussion must be evaluated by a physician or neuropsychologist before beginning the graduated return to play protocol.

I, _____, parent/legal guardian of _____, have received and understand the signs/symptoms and return to play guidelines as stated in the Campbell Clinic Concussion Policy.

_____ _____

Athlete's Name/Signature Parents Name/Signature

_____Date _____Date

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 or it's representative, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

EMERGENCY CONTACT 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 FOR ATHLETIC PARTICIPATION**

I hereby give my consent for _____ to represent

(Name of Student)

_____ in the sport of _____.

(Name of School)

Date: _____ Signature: _____

III. **TO PARENT/GUARDIAN:**

Due to new laws regarding release and disclosure of medical records, including pre-participation physicals, we are now required to obtain written authorization from you to release this information to your child's school/coaches. This information may be used strictly for determining medical clearance to participate for athletic purposes only. Please sign and date below:

I _____ parent/guardian of _____ authorize Campbell Clinic to release pre-participation physical to _____ High School and their coaches for athletic participation for the 2022-2023 school year.

_____ _____

Signature Date

Student-Athlete Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, physical therapists and sports medicine personnel representing Campbell Clinic to disclose protected health information regarding any injury or illness affecting the student-athlete's training for and participation in athletics at _____High School. Campbell Clinic is authorized to disclose this protected health information to any coach, the athletic director, or any school official in connection with his/her participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be disclosed to other health care providers within the Campbell Clinic system; to _____High School Administrators; and to officials of the Tennessee Secondary School Athletic Association.

I, _____, parent or guardian of _____,
(name of parent/guardian) (name of student)
understand that parent/legal guardian authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at High School and for care during interscholastic athletics. I understand that my child's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). This protected health information may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing Campbell Clinic. If authorization or consent is revoked, it will not have any effect on the actions Campbell Clinic personnel took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent is enacted on the date of signature and expires on May 31, 2023. Campbell Clinic will not condition your treatment on the signing of an authorization, except for any possible research-related treatment.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

_____ _____

Print Student-Athlete's Name Signature of Parent/Legal Guardian

_____

Date