KNOX COUNTY SCHOOLS

PHYSICAL EXAMINATION AND SPORTS MEDICAL PERMISSION

I/We hereby give consent for (student's name) ______________________________

to represent (name of school) ______________________________ in the sport(s) of ______________________________ realizing that such activity involves the potential for injury. I/We acknowledge that even with the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be severe and result in total disability, paralysis, or even death.

I/We further grant permission to (school)______________________________ , its physicians and/or Athletic Trainers to render aid, treatment, medical, or surgical care deemed reasonably necessary to protect the health and well being of the above individual.

I/We further release (school) ______________________________ , its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept full responsibility for any damages or injuries sustained as a result of participation in the sport(s) or extracurricular activity named above.

Student ______________________________ Parent/Guardian(s) ______________________________

Date ______________________________

EMERGENCY INFORMATION

Name ______________________________ Sport ______________________________ Sex: M _____ F _____

Grade __________ Age __________ Date of Birth _____ / _____ / ___________

Parent's Name ______________________________

Work Address ______________________________

Phone Number ______________________________ Cell 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) ______________________________

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

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 ____

	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

_______ Cleared without restriction

_______ Cleared, with recommendations for further evaluation or treatment for: ______________________________

_______ Not cleared for ________ All sports ____________ Certain Sports: ______________ Reason: ______________

Recommendations: ______________________________

Name of physician (print/type): ______________________________ **Date:**______________

Address:______________________________ **Phone:**______________

Signature of physician:______________________________, **MD or DO**

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.

1. Has a doctor ever denied or restricted your participation in sports for any reason? .... Y N
2. Do you have an ongoing medical condition (like diabetes or asthma)? .... Y N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? .... Y N
4. Do you have allergies to medicines, pollens, foods, or stinging insects? .... Y N
5. Have you ever passed out or nearly passed out DURING exercise? .... Y N
6. Have you ever passed out or nearly passed out AFTER exercise? .... Y N
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? .... Y N
8. Does your heart race or skip beats during exercise? .... Y N
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

10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) .... Y N
11. Has anyone in your family died for no apparent reason? .... Y N
12. Does anyone in your family have a heart problem? .... Y N
13. Has any family member or relative died of heart problems or of sudden death before age 50? .... Y N
14. Does anyone in your family have Marfan Syndrome? .... Y N
15. Have you ever spent the night in a hospital? .... Y N
16. Have you ever had surgery? .... Y N
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: ____________________________
18. Have you had any broken or fractured bones or dislocated joints? .... Y N
If Yes, explain: ____________________________
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: ____________________________
20. Have you ever had a stress fracture? .... Y N
21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? .... Y N
22. Do you regularly use a brace or assistive device? .... Y N
23. Has a doctor ever told you that you have asthma or allergies? .... Y N
24. Do you cough, wheeze or have difficulty breathing during or after exercise? .... Y N
25. Is there anyone in your family who has asthma? .... Y N
26. Have you ever used an inhaler or taken asthma medicine? .... Y N
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? .... Y N
28. Have you had infectious mononucleosis (mono) within the last month? .... Y N
29. Do you have rashes, pressure sores, or other skin problems? .... Y N
30. Have you ever had a herpes skin infection? .... Y N
31. Have you ever had a head injury or concussion? .... Y N
32. Have you been hit in the head and been confused or lost your memory? .... Y N
33. Have you ever had a seizure? .... Y N
34. Do you have headaches with exercise? .... Y N
35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? .... Y N
36. Have you ever been unable to move your arms or legs after being hit of falling? .... Y N
37. When exercising in the heat, do you have severe muscle cramps or become ill? .... Y N
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? .... Y N
39. Have you had any problems with your eyes or vision? .... Y N
40. Do you wear glasses or contact lenses? .... Y N
41. Do you wear protective eyewear, such as goggles or a face shield? .... Y N
42. Are you happy with your weight? .... Y N
43. Are you trying to gain or lose weight? .... Y N
44. Has anyone recommended you change your weight or eating habits? .... Y N
45. Do you limit or carefully control what you eat? .... Y N
46. Do you have any concerns that you would like to discuss with a doctor? .... Y N

FEMALES ONLY

47. Have you ever had a menstrual period? .... Y N
48. How old were you when you had your first menstrual period? ___
49. How many periods have you had in the last 12 Months? ______

Explain "Yes" answers here: ____________________________
____
____

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: __________

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