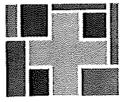

University Medical Center
The care you need from the people you know

1411 Baddour Parkway
Lebanon, TN 37087

TSSAA Preparticipation Medical Evaluation Form

PERSONAL HISTORY

Last Name	First Name	MI

Street____________________City____________
Zip__________Phone______________Sex: M / F
DOB____________Age___SS#________________
Father's Name____________________________
Home #_______________Work #____________
Mother's Name___________________________
Home #_______________Work #____________
Other Emergency Contact__________________
(relation)__________________Phone__________
Family Physician__________________________
Name of Personal Insurance________________

Upcoming Grade(circle) <7 7 8 9 10 11 12

School Name (check):

☐ Wilson Central	☐ Lebanon	☐ Mt. Juliet	☐ West Wilson Middle
☐ Walter J. Baird	☐ Friendship	☐ Watertown	☐ Watertown Middle
☐ Carroll Oakland	☐ Southside	☐ TXR	☐ Mt. Juliet Middle
		☐ Other	____________

Sport(s) (check):

☐ Baseball	☐ Cheer	☐ Hockey	☐ Tennis
☐ Boys Basketball	☐ X-Country	☐ Boys Soccer	☐ Track
☐ Girls Basketball	☐ Football	☐ Girls Soccer	☐ Volleyball
☐ Bowling	☐ Golf	☐ Softball	☐ Wrestling
	☐ Other:		

Parents, please answer ALL questions. Explain "YES" answers *(use additional sheet if necessary).*

#	Question	YES	#	NO
1	Have you ever had a preparticipation physical before? (☐ check if @ UMC)	☐	1	☐
2	Have you had any medical problems since your last evaluation?	☐	2	☐
3	Have you ever been hospitalized? Have you ever had surgery?	☐	3	☐
4	Do you have any allergies (to medications, foods, bees or stinging insects)?	☐	4	☐
5	Are you currently taking any medications and/or dietary supplements (creatine, vitamins, herbal supplements, etc.)?	☐	5	☐
6	Have you ever passed out during or after exercise?	☐	6	☐
7	Have you ever had chest pain, discomfort, or unexplained shortness of breath during or after exercise?	☐	7	☐
8	Do you tire during exercise more quickly than your friends?	☐	8	☐
9	Have you ever had high blood pressure or high cholesterol?	☐	9	☐
10	Have you ever been told that you have a heart murmur?	☐	10	☐
11	Has your heart ever raced or skipped beats?	☐	11	☐
12	Has any family member ever had a history of heart problems or of sudden death before the age of 50?	☐	12	☐
13	Do you have any skin problems (itching, rashes, acne)?	☐	13	☐
14	Have you ever been knocked out or unconscious, lost your memory, had a head injury, or concussion?	☐	14	☐
15	Have you ever had a seizure?	☐	15	☐
16	Have you ever had a stinger, burner, or pinched nerve?	☐	16	☐
17	Have you ever had heat or muscle cramps?	☐	17	☐
18	Have you ever become dizzy, ill, or passed out from exercising in the heat?	☐	18	☐
19	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	19	☐
20	Do you have asthma? (check ☐ yes if you have an inhaler)	☐	20	☐
21	Do you have any special equipment (pads, sports braces, neck roll/collar, mouth guard, eye guard)?	☐	21	☐
22	Do you have any problems with your eyes or vision?	☐	22	☐
23	Do you wear glasses, contacts, or protective eyewear? Eye Doctor____________	☐	23	☐
24	Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bones or joints? ☐ Head ☐ Neck ☐ Shoulder ☐ Back ☐ Chest ☐ Elbow/Arm ☐ Wrist/Hand ☐ Hip ☐ Thigh ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot	☐	24	☐
25	Have you ever had any other medical problems (infectious mononucleosis, diabetes, viral infections)?	☐	25	☐
26	When were your first and last menstrual periods (month/year)? (Females)________ / ________	☐	26	☐
27	What was the longest number of days between your periods last year? (Females)________	☐	27	☐

LEGAL MEDICAL CONSENT and PRIVACY STATEMENT

I/We hereby give consent for (athlete's name) ______________________________ to represent (name of school) ______________________________ in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of rules injuries are still possible. On rare occasions these injuries can be severe and result in total disability, paralysis, or even death.

I/We further grant permission to the school, its physicians, and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the student athlete named above. I/We further release the school, its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept the responsibility for any and all damages or injuries sustained as a result of participation in the sports(s) named above.

By the execution of this consent, the student athlete named above and his/her parent(s)/guardian(s) do hereby consent to the screening, examination, and testing of the student athlete during the course of the preparticipation examination by those personnel 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 examination of the student athlete on the forms attached hereto by those practitioners performing the examination.

The student athlete named above and his/her parent(s)/guardian(s) do also hereby consent to the dissemination of the information compiled from the preparticipation evaluation to the health care practitioners providing the service related to the preparticipation examination, the student athlete's coach(es) and the appropriate representatives of the school. This examination is not intended to replace a complete annual physical, which is recommended to all adolescents and should not be viewed as a substitute. In addition, this exam is not intended to interfere with any parent/physician relationship that currently exists.

I/We hereby acknowledge that I/we have received and understand the University Medical Center Notice of Privacy Practices for sports medicine services.

______________________________ Student Signature (if 18 yrs or older)

______________________________ Parent / Legal Guardian Signature

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(Please sign in BLUE or BLACK INK)

PHYSICAL EXAMINATION

Name________________ School__________ Sport______

General:
Height __________ **in.**
Weight __________ **lb.**
BP ______/______
Heart Rate_______

Vision: (L)_______ (R) _______
Corrected: ❒ Glasses
❒ Contacts
❒ Further evaluation recommended
❒ Further evaluation required for clearance
Eye professional:_______________

For office use:
❒ **Form screened**
❒ **M/S evaluation**

Urine Sample:
❒ Taken ❒ Not Required
❒ Not Taken

Musculoskeletal Examination

	WNL	See Flex Ed	See MD	Abnormal Findings	Physician Notes: Presently under care	Physician Notes: Requires further evaluation
Neck						
Shoulder / Arm						
Hip						
Knee						
Ankle						
Hamstring/Heel Cord						
Spine						

Medical Examination

	WNL	Abnormal Findings	Physician Notes: Presently under care	Physician Notes: Requires further evaluation
Head, Eyes				
Ear, Nose, Throat				
Heart				
Chest, Lungs				
Skin, Lymphatics				
Abdomen, Hernia				
Genitalia (Males)				

❒ **CLEARED FOR PARTICIPATION**

❒ **Cleared AFTER** completing evaluation / rehabilitation for:______________________

____

____

❒ **NOT CLEARED** for______________ Reason:______________________

❒ Recommendations or ❒ Conditions for participation (inhaler, bracing, taping, rehab, etc.)________

____

____

____

____

Physician Printed Name and Code ______________________

Physician Signature ______________________

Date __________