2017-2018 Pre-Participation Medical Evaluation Form
To be completed by Student & Parent/Guardian

Personal History

Name | Sex | Age | Date of Birth

Sports | School | Upcoming Grade - 2017

Personal Physician(s) | Address | Phone #

Have you ever had a pre-participation physical before? __ Yes __ No Where: _____

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please circle below: • Asthma • Anemia • Diabetes • Infections Other:_____		
3. Have you ever been hospitalized or had surgery?		
4. Are you presently takin any medications or pills?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise or in the heat?		
6. Have you ever had chest pain during or after exercise?		
7. Have you ever had racing or skipped heart beats?		
8. Has a doctor ever told you that you have any heart problems? If so, circle all that apply below: • High blood pressure • A heart murmur • High cholesterol • A heart infection • Kawasaki disease • Other:_____		
9. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram)		
10. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
11. Has anyone in your family died or had heart problems before age 50?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints? Check all that apply. _ Head _Shoulder _Thigh _Neck _Elbow _Knee _Chest _ Forearm _Shin/Calf _Back _Wrist _Ankle _Hip _ Hand _Foot		
13. Do you use any special equipment?		
MEDICAL QUESTIONS	**YES**	**NO**
14. Have you have trouble breathing, use an inhaler or taken asthma medicine?		
15. Do you have damage or absence of any paired organs? kidney, testicles, eyes etc?		
16. Have you had infectious mononucleosis?		
17. Do you have any skin problems? Rashes, itching, acne?		
18. Have you ever been knocked out or unconscious?		
19. Have you ever had a head injury?		
20. Do you ever had a seizure?		
21. Do you have headaches with exercise?		
22. Have you ever had a stinger, burner or pinched nerve?		
23. Have you ever had heat or muscle cramps?		
24. Have you or a family member had a history of sickle cell?		
25. Do you wear glasses, contact lenses, protective eyewear, such as goggles or a face shield?		
26. Are you on a special diet or do you avoid certain types of foods?		
27. Have you ever had an eating disorder?		
28. When was your last tetanus shot?		
29. When was your last measles immunization?		
FEMALES ONLY	**YES**	**NO**
30. How old were you when you had your first menstrual period?		
31. When was your last menstrual period?		
32. What was the longest time between periods last year?		

Explain 'Yes' answers here

_____

_____

2017-2018

Last Name First Name **Sport(s) interested in playing**
STUDENT

TMA / TSSAA Pre-Participation Medical Evaluation Form

To be completed by physician

Height: _____ Weight: _____ BP:_____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected: ___ Yes ___ No Pupils: _____

	Normal	Abnormal Findings
Ears / Nose / Throat		
Chest / Lungs		
Skin / Lymphatics		
Heart		
Abdominals		
Genitalia / Hernia		

Musculoskeletal Examination

	Normal	Abnormal Findings
Neck / Back		
Upper Extremities		
Lower Extremities		
Flexibility		

Optional Lab: Urine Sugar _____
Urine Protein _____
Urine Hematest _____

Official Recommendation

A. Based on the data gathered from this exam, this athlete __ **May** __ **May Not** compete in athletics.
B. Prior to participation, treatment or follow-up on the following is recommended:

_____

_____

C. Recommend further consultation with: _____

Physicians Signature: _____ Date: _____

This form cannot be completed prior to April 15, 2017 to be valid for 2017-2018 school year.