

Last Name First Name Sport(s) interested in playing
Pre-Participation Medical Evaluation Form
To be completed by Student & Parent/Guardian

Personal History

Name _____ Sex _____ Age _____ Date of Birth _____

Sports _____ School _____ Upcoming Grade - 2022 _____

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, burnner 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

Last Name First Name
STUDENT

Sport(s) interested in playing

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, 2022 to be valid for 2022-2023 school year.