

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 Orthopaedic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.