



PRE-PARTICIPATION MEDICAL EVALUATION FORM

Personal History

Name _____ Social Security # _____

Sex M / F Age _____ DOB _____ Grade _____

School _____ Sport(s) _____

Personal Physician _____ Address _____ Telephone _____

Have you ever had a pre-participation physical before? ___ Yes ___ No If yes, when/where _____

Please explain "Yes" answers below.

YES / NO

- 1 Have you ever been hospitalized? _____
- Have you ever had surgery? _____
- 2 Are you presently taking any medications or pills? _____
- 3 Do you have allergies (medicine, bees or other stinging insects)? _____
- 4 Have you ever passed out during exercise? _____
- Have you ever been dizzy during or after exercise? _____
- Have you ever had chest pain during exercise? _____
- Do you tire more quickly than your friends during exercise? _____
- Have you ever had high blood pressure? _____
- Have you ever been told that you have a heart murmur? _____
- Has anyone in your family died of heart problems or a sudden death before the age of 50? _____
- 5 Do you have any skin problems (itching, rashes, acne)? _____
- 6 Have you ever had a head injury? _____
- Have you ever been knocked unconscious? _____
- Have you ever had a seizure? _____
- Have you ever had a stinger, burner or pinched nerve? _____
- 7 Have you ever had heat or muscle cramps? _____
- Have you ever been dizzy or passed out in the heat? _____
- 8 Do you have trouble breathing or do you cough during or after activities? _____
- 9 Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)? _____
- 10 Have you had any problems with your eyes or vision? _____
- Do you wear glasses or contacts or protective eye wear? _____
- 11 Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints? _____

____ Head ____ Shoulder ____ Thigh ____ Neck ____ Elbow ____ Knee ____ Chest
____ Forearm ____ Shin/Calf ____ Foot ____ Back ____ Wrist ____ Ankle ____ Hip ____ Hand

- 12 Have you ever had any other medical problem (infectious mononucleosis, diabetes)? _____
- 13 Have you ever had a medical problem since your last evaluation? _____
- 14 When was your last tetanus shot? _____
- When was your last measles shot? _____
- 15 When was your first menstrual period? _____
- When was your last menstrual period? _____
- When was the longest time between your periods last year? _____

Please explain "yes" answers here:

I herby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete

Signature of Parent

Date

Signature of Coach

School

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected? _____ Yes _____ No _____ Pupils _____

Musculoskeletal Examination

| | Normal | Abnormal Findings |
|-------------------|--------|-------------------|
| Neck / Back | _____ | _____ |
| Upper Extremities | _____ | _____ |
| Lower Extremities | _____ | _____ |
| Flexibility | _____ | _____ |

General Examination

| | Normal | Abnormal Findings |
|---------------------|--------|-------------------|
| Ears, Nose & Throat | _____ | _____ |
| Heart | _____ | _____ |
| Chest / Lungs | _____ | _____ |
| Skin / Lymphatic | _____ | _____ |
| Abdominal | _____ | _____ |
| Genitalia / Hernia | _____ | _____ |

A. This athlete _____ may _____ may not compete in athletics based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is recommended:

Official Recommendation

C. Recommend further consultation with _____

Signature of Physician: _____ Date: _____



EMERGENCY TREATMENT

(Please Print)

LAST NAME _____ FIRST NAME _____ MI _____

SEX: MALE _____ FEMALE _____ GRADE: _____ AGE: _____ DOB: _____

ALLERGIES: _____

STUDENTS SS #: _____ INSURANCE: _____

General Information:

Father's Name: _____ SS#: _____

Work Address: _____ Work Phone: _____

Mother's Name: _____ SS#: _____

Work Address: _____ Work Phone: _____

Home Address: _____ Home Phone: _____

Father's Cell #: _____ Mother's Cell #: _____

Another Person to Contact: _____ Phone: _____

Relationship: _____

Legal/Parent Consent:

I/We hereby give consent for (athlete's name) _____ to represent _____ 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 disability, paralysis, and even death. I/We further grant permission to the school, its physicians, athletic trainers and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above. By the execution of this consent, the student athlete named above and his/her parents/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation 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 student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.

Student Signature

Parent/Guardian Signature

Date

**Authorization for Use or
Disclosure of Protected Health Information**

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

1. I authorize Baptist Hospital to:

Use my health information as described below; and/or

XX Disclose my health information to the following individual or organization:

Hillsboro High School

Address: **3812 Hillsboro Pike, Nashville, TN 37215**

2. The purpose(s) for the use or disclosure is as follows: SPORTS INJURIES AND ILLNESSES

RELATED TO SPORTS PERFORMANCE

3. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from

| N/A | to | N/A |
|--|----|--|
| Date of Service | | Date of Service |
| <input type="checkbox"/> Abstract (Includes H&P, Progress notes, Procedure reports, Consult, DS, Diagnostic Testing, and all dictated reports.) | | <input type="checkbox"/> Summary |
| <input type="checkbox"/> Copy of Medical Record only | | <input type="checkbox"/> Discharge Summary (DS) |
| <input type="checkbox"/> Copy of Complete Record (medical records and financial records) | | <input type="checkbox"/> Operative / Procedure Report (OP) |
| XX History and Physical (H&P) | | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Consultation | | <input type="checkbox"/> Laboratory Report |
| | | <input type="checkbox"/> X-Ray Report |

Other: INFORMATION REGARDING SPECIFIC INJURIES I MAY INCUR DURING SPORTS PARTICIPATION

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.
5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that my revocation will not apply to the extent that Baptist Hospital has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: JUNE 1, 2006. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Baptist Hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize Baptist Hospital to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 615-284-8223.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED