



7297 SPARTA PIKE • WATERTOWN, TENNESSEE 37184  
 P: 615-237-0015 • F: 615-237-0021 • WWW.CVFAMILYCARE.COM

*Our Family... Caring for Yours.*

Jim Cheeks, NP | Lynn Corlew, NP | Bruce McLaughlin, NP

**TSSAA PREPARTICIPATION MEDICAL EVALUATION FORM**

Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS# \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Other Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_  
 Primary Care Provider \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Upcoming Grade < 6 7 8 9 10 11 12      Name of School \_\_\_\_\_

Parents, please answer ALL questions Explain YES answers (Use additional sheet if necessary)

- |  |     |    |
|--|-----|----|
| 1. Have you ever had a preparticipation physical before?   | Yes | No |
| 2. Have you ever had chest pain or chest discomfort during or after exercise?  | Yes | No |
| 3. Have you ever passed out during or after exercise?  | Yes | No |
| 4. Do you have excessive and unexplained tiredness/fatigue associated with exercise?   | Yes | No |
| 5. Have you ever been told that you have a heart murmur?   | Yes | No |
| 6. Have you ever had high blood pressure?  | Yes | No |
| 7. Has any family member suffered a disability from heart disease before the age of 50?  | Yes | No |
| 8. Has any family member had Premature Sudden Death before the age of 50 due to heart disease?   | Yes | No |
| 9. Do you have knowledge of any family members with the following specific cardiac conditions:<br>Hypertrophic or Dilated Cardiomyopathy, Long-QT Syndrome or Marfan Syndrome? | Yes | No |
| 10. Do you have any medical problems?  | Yes | No |
| 11. Have you ever been hospitalized? Had surgery   | Yes | No |
| 12. Do you have any allergies?(medication, foods, bees etc)  | Yes | No |
| 13. Are you currently taking any medications or supplements?   | Yes | No |
| 14. Do you have any skin problems?   | Yes | No |
| 15. Have you ever been knocked out or unconscious, lost memory, had a head injury?   | Yes | No |
| 16. Have you ever had a seizure?   | Yes | No |
| 17. Have you ever had a stinger, burner, or pinched nerve?   | Yes | No |
| 18. Have you ever had heat or muscle cramps?   | Yes | No |
| 19. Have you ever become dizzy or passed out from exercising in the heat?  | Yes | No |
| 20. Do you cough, wheeze or have trouble breathing during or after activity?   | Yes | No |
| 21. Do you have asthma? Check yes ___ if you have use an inhaler   | Yes | No |
| 22. Do you have any special equipment (pads, sports brace, neck roll/collar, eye guard etc..)  | Yes | No |
| 23. Do you have any problems with your eyes or vision?   | Yes | No |
| 24. Do you wear glasses or contacts, or protective eyewear? Eye Dr. _____  | Yes | No |
| 25. Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bone or joints? Yes No  |     |    |
| ___Head    ___Neck    ___Shoulder    ___Back    ___Chest    ___Elbow/Arm   |     |    |
| ___Hand/Wrist    ___Hip    ___Thigh    ___Knee    ___Shin/calf    ___Ankle    ___Foot  |     |    |
| 26. What year was your last tetanus shot? _____  |     |    |
| 27. When were your first and last menstrual periods (month/year)? _____/_____(Females only)  |     |    |
| 28. What was the longest number of days between your periods last year? _____ (Females only)   |     |    |

**Legal Medical Consent and Privacy Statement**

We hereby give Consent for \_\_\_\_\_ to represent (name of school) \_\_\_\_\_ in Athletics realizing that such activity involves the potential for injury.

We further grant permission to the school, physical and athletic trainer to give medical treatment or surgical care deemed reasonable and necessary to the health and well being of this student.

\_\_\_\_\_  
 (Student Signature—if 18 years or older)

\_\_\_\_\_  
 Parent/Legal Guardian Signature)

\_\_\_\_\_  
 Date



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PHYSICAL EXAMINATION

Name \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ in Weight \_\_\_\_\_ lbs BP \_\_\_\_\_ Heart rate \_\_\_\_\_

Vision : (L) (R)  
 20/20 20/20 Further Evaluation recommended \_\_\_\_\_

Other \_\_\_\_\_ Further evaluation required \_\_\_\_\_

Corrected: Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Musculoskeletal Examination

	WNL	Abnormal Findings	Presently under care	Requires further evaluation
Neck/Spine				
Shoulder/Arm				
Hip				
Knee				
Ankle				
Hamstring/Heel Cord				
Evidence of Marfan Syndrome				

Medical Examination

	WNL	Abnormal Findings	Presently under Care	Requires further evaluation
HEENT				
Cardiovascular/ Femoral Pulses/ Murmur				
EKG (if indicated)				
Respiratory				
Skin, Lymphatic				
Abdomen, Hernia				
Genitalia (Males)				

\_\_\_\_\_ Cleared for Participation

\_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_ Not cleared for: \_\_\_\_\_

\_\_\_\_\_ Recommendations or Conditions for Participation: \_\_\_\_\_

\_\_\_\_\_ Provider's Signature Date \_\_\_\_\_