mount juliet Family care & WALK-IN CLINIC

754 NORTH MOUNT JULIET ROAD • MOUNT JULIET, TENNESSEE 37122
P:615-754-2828 • F:615-754-2818 • WWW.MJFAMILYCARE.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: 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 _____