**PLEASE PRINT Pre-Participation Physical**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last First M. I.**

**Preferred name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex: M F Date of Birth: \_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MM/DD/YYYY**

**Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Apt.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:**\_\_\_\_\_\_\_\_\_\_ **Zip Code** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alt. Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parents’ Permission/HIPAA Release/Acknowledgement of Risk for Athletic Participation**

As the parents or legal guardian of the above named student-athlete, I give my consent for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information/records/documentation. Participation in Football requires and acceptance of the risk of injury. By my signature below I acknowledge that I accept the risk of participation in the sport of Football and travels to and from play and practice, and give my consent to participation. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means. My signature below indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

I give consent for the head athletic trainer at GTSA to **release** such information regarding my child’s medical history and/or records that pertain directly to athletic participation at GTSA. This information may be requested by agents of any amateur or professional athletic organization, college or university, or insurance company. I also grant permission for the GTSA athletic trainer to **receive** medical information from any medical practice concerning my child’s athletic injury information for the continuity of care. This information may be transmitted via telephone, personal interview, electronic mail, postal service, fax, or other form of media not listed here.

**PRINT NAME**, Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Emergency Medical Treatment**

As a parent/guardian of the student-athlete named in this document, I/we hereby grant permission and consent to the GTSA Head Athletic Trainer, Sports Medicine Staff, and Coaching Staff for the following:

1. Provision of treatment for athletic injuries
2. Provision of appropriate medical/emergency attention that may be deemed necessary
3. To act on my behalf in the case of a medical emergency requiring transport to and treatment at a hospital or other medical/urgent care facility
4. To the physician and/or appropriate medical personnel to attend to my child
5. To the physician, coaches, administration, and athletic trainer for the release of medical information pertaining to the treatment and rehabilitation of my child’s injury(s) via fax, email, paper, telephone, and/or computer.

Parent/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you have health insurance? If yes, see below.

Yes No Do you have Medicaid? If yes, Medicaid number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Does your insurance require you to get a referral from your family physician prior to seeing a specialist (orthopaedist,

neurologist, general surgeon, etc.)

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Medical History for Pre-Participation Physical**

Circle “Yes” or “No” for each question. Circle the number for each question that you do not completely understand.

Yes No 1. Have you had a medical illness or injury since your last check-up/physical?

Yes No 2. Have you ever been hospitalized overnight?

Yes No 3. Do you have an ongoing or chronic illness?

Yes No 4. Are you currently taking any prescription or OTC medication or use an inhaler?

Yes No 5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?

Yes No 6. Do you have any allergies to pollen, medicine, food, or stinging insects?

Yes No 7. Have you ever had a rash or hives develop during or after exercise?

Yes No 8. Have you ever passed out during or after exercise?

Yes No 9. Have you ever been dizzy during or after exercise?

Yes No 10. Have you ever had chest pain, chest discomfort, or unexplained shortness of breath during or after exercise?

Yes No 11. Do you get tired more quickly than your friends do during exercise?

Yes No 12. Have you ever had a racing of your heart or skipped heart beats?

Yes No 13. Have had high blood pressure or high cholesterol?

Yes No 14. Have you ever been told that you have a heart murmur?

Yes No 15. Has any family member or relative died of heart problems or sudden death before the age of 50?

Yes No 16. Has any relative younger than 50 ever had disability from heart or cardiovascular disease?

Yes No 17. Do you have any family member or relative with ANY heart condition including but not limited to Marfans,

cardiomyopathy, or arrhythmia?

Yes No 18. Have you ever had a severe viral infection such as myocarditis or mononucleosis within the last month?

Yes No 19. Has a physician ever denied or restricted your participation in sports for any heart problems?

Yes No 20. Do you have any current skin problems such as itching, rashes, acne, warts, fungus, or blisters?

Yes No 21. Have you ever had a head injury or concussion?

Yes No 22. Have you ever been knocked unconscious or ever lost your memory?

Yes No 23. Have you ever had a seizure?

Yes No 24. Do you have frequent or severe headaches?

Yes No 25. Have you ever had numbness or tingling in your arms, hands, legs, or feet?

Yes No 26. Have you ever had a “stinger,” “burner,” or pinched nerve?

Yes No 27. Have you ever become ill from exercising in the heat?

Yes No 28. Do you cough, wheeze, or have trouble breathing during or after activity?

Yes No 29. Do you have asthma?

Yes No 30. Do you use an inhaler? What name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No 31. Do you have seasonal allergies that require medical treatment?

Yes No 32. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or

position? Example: knee/ankle brace, orthotics, dental retainer, hearing aid

Yes No 33. Have you had any problems with your vision or eyes?

Yes No 34. Do you wear (circle all that apply): glasses contacts protective eyewear

Yes No 35. Have you ever had a sprain, strain, or swelling after injury?

Yes No 36. Have you ever fractured/broken any bones?

Yes No 37. Have you ever dislocated any joints?

Yes No 38. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?

Yes No 39. Do you want to lose or gain weight?

Yes No 40. Do you lose weight regularly to meet weight requirements for your sport?

Yes No 41. Do you have a family history of Sickle Cell Anemia?

**Pre-Participation Physical Examination**

**Height** \_\_\_\_\_\_\_\_\_\_\_\_\_ inches **Weight** \_\_\_\_\_\_\_\_\_\_\_\_ pounds **Pulse**, R \_\_\_\_\_\_\_\_\_\_\_\_ OR L \_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Pressure**: **Right** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR **Left** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision**: **L** 20/ \_\_\_\_\_\_\_\_\_ **R** 20/ \_\_\_\_\_\_\_\_\_ **Vision, corrected**: **L** 20/ \_\_\_\_\_\_\_\_\_ **R** 20/ \_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medical** | **Normal** | **Abnormal Findings** |
| Pupils |   |   |
| EENT |   |   |
| Lungs |   |   |
| Heart |   |   |
| Abdomen |   |   |
| Skin |   |   |
| Lymph nodes |   |   |
|   |   |   |
| **Musculoskeletal** | **Normal** | **Abnormal Findings** |
| Neck |   |   |
| Back |   |   |
| Shoulder/Arm |   |   |
| Elbow/Forearm |   |   |
| Wrist/Hand |   |   |
| Hip/Thigh |   |   |
| Knee |   |   |
| Leg/Ankle |   |   |
| Foot |   |   |

**CLEARED** for all sports EXCEPT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEEDS FURTHER EVALUATION** FOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Clearance Physician signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOT CLEARED** DUE TO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD or DO Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sports Medicine Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_