

Name: _____

School: _____

Information below is to be completed by medical staff only.

Height _____ Weight _____ BP _____ / _____ Pulse _____

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

Musculoskeletal Examination

Examiner: _____

Been to Physician in past 2 years for muscle, joint, or bone pain? ____ No ____ Yes: _____

	Normal	Abnormal Findings
Neck/Back	_____	_____
Upper Extremities	_____	_____
Lower Extremities	_____	_____
General Strength	_____	_____
General Flexibility	_____	_____

General Examination

Examiner: _____

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

General Notes / Other:

Official Recommendation

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** / **required** :

C. Recommend further consultation with _____

TSSAA Approved Examiner: (Print) _____ (Sign) _____ Date: _____

TSSAA PRE-PARTICIPATION EVALUATION

CLEARANCE FORM

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

GRADE: _____ SCHOOL: _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for: _____

_____ Not cleared for _____ All sports _____ Certain Sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

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 _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of TSSAA Approved Examiner: _____

Adapted 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.

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I. EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name: _____ Sport: _____ Sex: M _____ F _____

Grade: _____ Age: _____ Date of Birth: ____/____/____

Parent's Name: _____

Work Address: _____

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): _____

II. PARENT'S CONSENT

I hereby give my consent for _____ to represent
(Name of Student)
_____ in the sport of _____.
(Name of School)

Date: _____ Signature: _____