

TOA

TENNESSEE ORTHOPAEDIC ALLIANCE

To: Rutherford County High School and Middle School Athletic Directors and Coaches
From: Brad Rohling, Athletic Training Coordinator
Date: February 13, 2019
RE: Pre-Participation Athletic Exams for 2019-2020 for Rutherford County Athletes

Tennessee Orthopaedic Alliance and physicians/staff from Middle Tennessee Medical Center will again offer free pre-participation exams for prospective Rutherford County middle and high school student athletes on Saturday, April 27, 2019. To make this day go as smooth as possible, please note the following:

- Exams will be at TOA, 1800 Medical Center Parkway, in Murfreesboro, not at each individual school.
- Please have the correct form and all required parent/guardian signatures filled out at the time of arrival.
- **This will be the only opportunity for athletes to receive these exams – no make-up will be done.**
- Athletes are not required to attend these exams, but a physical is required for participation in sports.
- Please avoid any caffeine/energy drinks. Blood pressure will be taken and athlete may not be cleared.
- Athletes should dress in shorts/t-shirts to allow physicians to evaluate extremities as needed.
- Athletes must present all appropriate forms, completed and signed by parent. Athletes without completed and signed forms will not be eligible to receive an exam. **Please have all pages filled out with all required parent signatures before the time of entrance.** If you have not created a DragonFly Max account, instructional information will be on the TOA website, www.TOA.com. If you have completed the forms on DragonFly Max, please print off the history, consent for athletic participation, travel, and medical care, and blank physical form. **Printers will not be available the day of exams.**
- Contact information is listed below. Please do not contact TOA with questions about exams.
- Parents are welcome to accompany their children throughout the entire process.
- Exams will be complimentary; however, donations will be accepted. Proceeds will be used to purchase medical equipment used by the Rutherford County Athletic Trainers.
- Please note that some medical problems detected during physical exam may require clearance from the athlete's physician. Parents may wish to schedule a complete physical evaluation from their physician.
- **Each student is responsible for delivery of forms to their coach – copies will not be available.**

Please adhere to the scheduled times for your school listed below. A small wait should be expected.

- | | |
|--------|---|
| 7:45AM | Smyrna High, Siegel High, Riverdale High, Rockvale High, Siegel Middle, Smyrna Middle, Rockvale Middle, Christiana Middle, Whitworth-Buchanan |
| 8:30AM | Oakland High, Blackman High, MTCS, Oakland Middle, Blackman Middle, Lancaster Christian, Thurman Francis, Eagleville, Rocky Fork Middle |
| 9:15AM | LaVergne High, Stewarts Creek High, Holloway, Rock Springs Middle, LaVergne Middle, Central Magnet, Providence Christian, Stewarts Creek Middle, FRCS |

Please contact Brad Rohling at toaphysicals@hotmail.com as soon as possible should there be any conflicts with scheduled times. Do not hesitate to email with problems, questions, or concerns. Please do not contact the physicians/staff of TOA with questions.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____

Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

CONSENT FOR ATHLETIC PARTICIPATION, TRAVEL, AND MEDICAL CARE

***Entire page to be completed by parent/legal guardian*

Athlete Information

Last Name _____ First Name _____ MI _____
Gender: () Male () Female Grade _____ Age _____ DOB ____/____/____
Known Medical Problems _____
Allergies _____ Medications _____
Name of Athlete's Physician _____ Phone #(s) _____
Insurance _____ Policy # _____
Group # _____ Insurance Phone #(s) _____

Emergency Contact Information

Home Address (include city, state, zip) _____ Phone () _____
Mother's Name _____ Cell () _____ Work () _____
Father's Name _____ Cell () _____ Work () _____
Alternate Contact Name _____ Relationship _____ Phone () _____

Legal Parent (Guardian) Consent

I/We hereby give consent for **(athlete's name)** to represent (name of school) _____ in athletics, including related travel, realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible., **On rare occasions these injuries are severe and result in disability, paralysis, or even death. I/We further grant permission to the school and TSSAA, 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 during or resulting from participation in athletics.** By execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent(s) or legal guardian(s), **I/we remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.**

Signature of Athlete

Signature(s) of Parent(s)/Legal Guardian(s)

Date

Personal Affidavit In Lieu Of School Insurance

All students who participate in any school-sponsored athletic sport must take out school insurance or file with the principal an affidavit form that they or their insurance company will be responsible for payment in case of injury.

State Of Tennessee / Rutherford County School System

I/We _____, make oath in due form of law that I/We am/are the parents/ guardians of _____
Name of Parent(s)/Guardian(s)
_____ who is a student of _____ and that I/we hereby join in the application of said applicant:
Name of Student *Name of School*

(Check One*)

- ____ 1. To be personally
____ 2. To have my/our insurance company

Insurance Company _____ *Policy Number* _____

responsible for payment of any injury sustained at said school while participating in school-sponsored sports.

Date

Signature(s) of Parent/Guardian