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](http://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 toaphyscials@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

Sex

Age

Grade

School

Sport(s)

Date of birth

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

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 list below: □ Asthma  □ Anemia  □ Diabetes  □ Infections

3. Have you ever spent the night in the hospital?

4. Have you ever had surgery?

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:

□ High blood pressure  □ A heart murmur  □ High cholesterol  □ A heart infection

□ Kawasaki disease  □ Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EOG, 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 YOU

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 a heart problem, pacemaker, or implanted defibrillator?

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

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 you have 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

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?

27. Have you ever used an inhaler or taken an 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

PHYSICIAN REMINDERS

1. 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?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

Height

Weight

□ Male □ Female

BP /

Pulse

Corrected □ Y □ 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

- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

Pulses

- Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only)*

Skin

- HSV, lesions suggestive of MRSA, linea corporis

Neurologic

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toes

Functional

- Duck-walk, single leg hop

Courses

Pending further evaluation

For any sports

For certain sports

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)

Address

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 __________________________________________ Mediations __________________

Name of Athlete’s Physician ______________________  Phone #(s) __________________

Insurance ______________________________________________________________________

Group # ______________________  Insurance Phone #'(s) ______________________

Emergency Contact Information

Home Address (include city, state, zip) _____________________________________________

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 ____________________________________________ 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