Traverse City Area Public Schools Preparticipation Physical Evaluation

To be completed by parent/guardian and student

Name ________________________________ School ________________________________

Sex **M** **F** Date of Birth ______________ Age ________________ Grade ______________

Parent/Guardian ____________________________ Parent/Guardian ____________________________

Phone (H) ____________ Phone (W) ____________ Phone (H) ____________ Phone (W) ____________

Personal Physician ____ Phone ______________________

In case of emergency, contact:

Name ______________________ Relationship ________________ Phone ______________

Sports Medicine/Emergency Consent for Treatment

Traverse City Area Public School employs a Certified Athletic Trainer, who is qualified to evaluate and treat many injuries your child might incur while participating in athletics. This Trainer works under the direction of Munson Medical Center's Medical Director of Sports Medicine. In the event that physician consultation is required for your child, the Athletic Trainer will contact you either by phone or through written communication. In all cases, the parent/guardian has the right to determine from whom their child receives care. However, in the event of an emergency, the need for prompt action may preclude reaching the parent first. By answering the questionnaire and signing the appropriate statements that follow, you will allow us to raise the level of care we can provide our student athletes.

Emergency Treatment Permit/Limited Power of Attorney

The undersigned does hereby grant permission to Certified Athletic Trainers contracted by Traverse City Area Public Schools to evaluate and treat the above named athlete as appropriated AND does hereby grant to the individuals listed below (in addition to the Certified Athletic Trainer) responsibility to authorize treatment for the above named athlete in case of medical emergency as a result of participating in any sport supervised by Traverse City Area Public Schools, during the upcoming school year.

1)____ 1)______________________
Name of Coach/Limited Power of Attorney Sport

____
Name of Insurance Company Policy Holder's Name Group # Policy #

____
Parent/Guardian Signature Date

Health History

Circle "yes" or "no". Explain "Yes" answers below. Indicate questions you don't know the answer to.

Question		
1. Have you had a medical illness or injury since your last check up or sports physical?	Yes	No
Do you have any ongoing or chronic illness?	Yes	No
2. Have you ever been hospitalized overnight?	Yes	No
Have you ever had surgery?	Yes	No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills, or using an inhaler?	Yes	No
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Yes	No
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	Yes	No
Have you ever had a rash or hives develop during or after exercise?	Yes	No
5. Have you ever passed out during or after exercise?	Yes	No
Have you ever been dizzy during or after exercise?	Yes	No
Have you ever had chest pain during or after exercise?	Yes	No
Do you get tired more quickly than your friends do during exercise?	Yes	No
Have you ever had racing of your heart or skipped heartbeats?	Yes	No
Have you had high blood pressure or high cholesterol?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	Yes	No
Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
6. Do you have any current skin problems (for example, itching, rashes, warts, fungus or blisters)?	Yes	No
7. Have you ever had a head injury or concussion?	Yes	No
Have you ever been knocked out, become unconscious, or lost your memory?	Yes	No
Have you ever had a seizure?	Yes	No
Do you have frequent or severe headaches?	Yes	No
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No
Have you ever had a stinger, burner, or pinched nerve?	Yes	No
8. Have you ever become ill from exercising in the heat?	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?	Yes	No
Do you have asthma?	Yes	No
Do you have seasonal allergies that require medical treatment?	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	Yes	No
11. Have you ever had any problems with your eyes or vision?	Yes	No
Do you wear glasses, contacts, or protective eyewear?	Yes	No
12. Have you ever had a sprain, strain, or swelling after injury?	Yes	No
Have you broken or fractured any bones or dislocated any joints?	Yes	No
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	Yes	No

If yes, check appropriate box and explain below:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/calf
Shoulder	Finger	Ankle
Upper Arm		Foot

Question		
13. Do you want to weigh more or less than you do now?	Yes	No
Do you lose weight regularly to meet weight requirements for your sport?	Yes	No
14. Record the dates of your most recent immunizations:		

Tetanus______________ Hepatitis B____________

FEMALES ONLY

Question		
15. Do you have any menstrual problems or concerns?	Yes	No

EXPLAIN "YES" ANSWERS:

Traverse City Area Public Schools Preparticipation Physical Evaluation

(To be completed by parent/guardian and student)

PERMIT TO PARTICIPATE

Name____Grade___________School________________________

I hereby give my consent for the above named student to participate in interscholastic athletics as offered by Traverse City Area Public Schools, and to accompany such teams as a member on its out of town trips. Recognizing that as a result of participation in interscholastic athletic contests and practice sessions, the possibility of injury exists. I agree not to hold Traverse City Area Public Schools liable for any such injuries incurred. Medical information withheld, incomplete, or incorrect relieves Traverse City Area Public Schools form all medical-legal liability and may disqualify your son/daughter from participation on any Traverse City team.

Parent/Guardian signature____ **Date**___________________________

This application for the privilege to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules of the M.H.S.A.A. or the Traverse City Area Public Schools.

Student signature____ **Date**___________________________

WAIVER OF LIABILITY FOR SPORTS PHYSICAL EXAMINATION GIVEN AT SCHOOL

I hereby give my consent for the above named student to undergo a physical examination to determine his/her fitness to engage in competitive sports. I understand that the physician, who is performing this exam without compensation, is not performing a complete physical examination. I understand as provided by Michigan Law (MCI 691.1501 sec. 2) that the physician is not liable for civil damages as a result of acts or omissions which may occur in performing the examination, except acts or omissions amounting to gross negligence or willful and wanton misconduct of which are outside the scope of the license held by the physician.

Parent/Guardian signature____ **Date**___________________________

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Traverse City Area Public Schools Preparticipation Physical Examination

(To be Completed by Medical Professional)

Name____Sex **M F** Birth Date________________Age____________

Height________________Weight________________Pulse________________BP (1)________(2)________(3)_________

Vision R20/____ L20/____Corrected: **Y N** Flexibility _____________ Exercise Sheet _______________________

ENT	Normal	Findings	Initials
Eyes/Ears			
Nose/Throat			
Lymph Nodes			
General Appearance			
LUNGS			
Marfan's Stigmata	Yes	No	
HEART			
Rhythm	Regular	Irregular	
Murmur	Yes	No	

ABDOMEN	Normal	Findings	Initials
Abdomen			
Genitalia (males)			
Skin			
MUSCULOSKELETAL			
Spine			
Shoulder/Arm			
Hip/Knee			
Chronic Conditions:			

I certify that I have examined the above student and have found him/her medically
Eligible **Not Eligible** to compete in supervised athletic activities.

Follow-up needed for eligibility: ____

Follow-up information given/School Nurse: ____

Signature of Health Care Provider/Physician____Date__________________