



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

_____ **Yes**, we have our own insurance policy. Name of insurance carrier: _____

_____ **No**, we do not have insurance and will purchase student insurance offered through the school.

Parent/Guardian Signature _____ Date _____

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

<p>1. Have you had a medical illness or injury since your last check up or sports physical? Do you have any ongoing or chronic illness?</p> <p>2. Have you ever been hospitalized overnight? Have you ever had surgery?</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills, or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</p> <p>4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise?</p> <p>5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?</p> <p>6. Do you have any current skin problems (for example, itching, rashes, warts, fungus or blisters)?</p> <p>7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?</p>	Yes	No	<p>8. Have you ever become ill from exercising in the heat?</p> <p>9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?</p> <p>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)?</p> <p>11. Have you ever had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?</p> <p>12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?</p> <p>If yes, check appropriate box and explain below:</p> <table border="1"> <tr> <td>Head</td> <td>Elbow</td> <td>Hip</td> </tr> <tr> <td>Neck</td> <td>Forearm</td> <td>Thigh</td> </tr> <tr> <td>Back</td> <td>Wrist</td> <td>Knee</td> </tr> <tr> <td>Chest</td> <td>Hand</td> <td>Shin/calf</td> </tr> <tr> <td>Shoulder</td> <td>Finger</td> <td>Ankle</td> </tr> <tr> <td>Upper Arm</td> <td></td> <td>Foot</td> </tr> </table> <p>13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?</p> <p>14. Record the dates of your most recent immunizations: Tetanus _____ Hepatitis B _____</p> <p>FEMALES ONLY</p> <p>15. Do you have any menstrual problems or concerns?</p> <p>EXPLAIN "YES" ANSWERS:</p>	Head	Elbow	Hip	Neck	Forearm	Thigh	Back	Wrist	Knee	Chest	Hand	Shin/calf	Shoulder	Finger	Ankle	Upper Arm		Foot	Yes	No
	Head	Elbow		Hip																			
Neck	Forearm	Thigh																					
Back	Wrist	Knee																					
Chest	Hand	Shin/calf																					
Shoulder	Finger	Ankle																					
Upper Arm		Foot																					
Yes	No	Yes	No																				



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 **engage** in interscholastic athletics as offered by Traverse City Area Public Schools and **for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. I understand the possibility that serious injury may result from participating in athletic activities.** I agree not to hold Traverse City Area Public Schools liable for any such injuries incurred. **My son/daughter has my permission to accompany their team** 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. Medical information withheld, incomplete, or incorrect relieves Traverse City Area Public Schools from 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 the information submitted is truthful to the best of my knowledge. I have never received money or negotiable certificates for merchandise in any amount, nor an emblematic award or merchandise worth more than the amount allowed by the MHSAA for participating in athletic events, nor have I ever competed under an assumed name. After I have represented my school in any sport, I will not compete in any outside athletic contest in this sport until after my school season has been completed. I understand that I am expected to adhere firmly to all established athletic policies of my school district and the MHSAA, such as those previously mentioned above as examples but which do not present all the policies to which I am subject.

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 (MCL 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	ABDOMEN		Normal	Findings	Initials
Eyes/Ears					Abdomen				
Nose/Throat					Genitalia (males)				
Lymph Nodes					Skin				
General Appearance					MUSCULOSKELETAL				
LUNGS					Spine				
Marfan's Stigmata		Yes	No		Shoulder/Arm				
HEART					Hip/Knee				
Rhythm		Regular	Irregular		Chronic Conditions:				
Murmur		Yes	No						

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 _____