



Father Ryan High School and TSSAA Pre-Participation Evaluation Form

To be filled out and signed by Parents/Guardian

2011-2012 School Year

\$30 Athletic Fee must accompany these forms

Personal History

Name _____ M ___ F ___ Age ___ DOB _____ Grade _____ (2011-2012 School Year)

Sport(s) _____ Personal Physician _____ Dr. Phone _____

Have you ever had a pre-participation physical before? Yes ___ No ___ If yes, when/where _____

- 1. Have you ever been hospitalized? Yes No
Have you ever had surgery? Yes No
2. Are you presently taking any medications or pills? Yes No
3. Do you have allergies (medicine, bees or other stinging insects)? Yes No
4. Have you ever passed out during exercise? Yes No
Have you ever been dizzy during or after exercise? Yes No
Have you ever had chest pain during exercise? Yes No
Do you tire more quickly than your friends during exercise? Yes No
Have you ever had high blood pressure? Yes No
Have you ever been told that you have a heart murmur? Yes No
Has anyone in your family died of heart problems or a sudden death before the age of 50? Yes No
5. Do you have any skin problems (itching, rashes, acne)? Yes No
6. Have you ever had a head injury? Yes No
Have you ever been knocked unconscious? Yes No
Have you ever had a seizure? Yes No
Have you ever had a stinger, burner or pinched nerve? Yes No
7. Have you ever had heat or muscle cramps? Yes No
Have you ever been dizzy or passed out in the heat? Yes No
8. Do you have trouble breathing or do you cough during or after activities? Yes No
9. Do you use any special equipment (pads, braces, neck roll, mouth guard, eye guard)? Yes No
10. Have you had any problems with your eyes or vision? Yes No
Do you wear glasses or contacts or protective eye wear? Yes No
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of bones or joints? Yes No
Check all that apply below:
Head Shoulder Thigh Neck Elbow
Knee Chest Forearm Shin/Calf Foot
Back Wrist Ankle Hip Hand
12. Have you ever had any other medical problem (Infectious mononucleosis, diabetes)?
13. Have you ever had a medical problem since you last evaluation?
14. When was your last tetanus shot? When was your last measles shot?
15. When was your first menstrual period? When was your last menstrual period?
When was the longest time between your periods last year?

Please explain any "yes" answers here:

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

Student-Athlete Signature

Parent/Guardian Signature

Consent Forms - Filled out and Signed by Parents/Guardian

Emergency Treatment

Last Name _____ First Name _____ MI ___ M ___ F ___ Grade _____ Age _____
Allergies _____ Student SS# _____

General Information

Father's Name: _____ SS# _____ Work Phone _____ Cell Phone _____

Mother's Name: _____ SS# _____ Work Phone _____ Cell Phone _____

Work Address: _____

Home Address: _____ City _____ Zip _____ Home Phone _____

Another Person to Contact: _____ Relationship to student _____ Phone _____

Legal/Parent Consent

I/We hereby give consent for (athlete's name) _____ to represent Father Ryan High School in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of rules, injuries are still possible. On rare occasions these injuries can be severe and result in disability, paralysis, and even death. I/We further **grant permission to the school, its physicians, EMT, and/or athletic trainers to render aid, treatment, medical, or surgical care deemed reasonable necessary to the health and well being of the student athlete named above.** By the execution of the consent, the student athlete named above and his/her parents/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those personnel performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination.

As parent or legal Guardian, I/we remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.

Student-Athlete Signature

Parent/Guardian Signature

Travel Consent

I agree to allow my son or daughter to ride with a coach in a bus or car for the purpose of transportation to or from a Father Ryan High School sanctioned event.

Student Passenger _____ Parent/Guardian Name _____

Parent/Guardian Signature

Date

Authorization for Use or Disclosure of Protected Health Information

Filled out and Signed by Parents/Guardians

Patient Name _____ Social Security Number: _____

Date of Birth _____ Phone Number: _____

1. I authorize **Star Physical Therapy** to:

* Use my health information as described below; and/or disclose my health information to the following individual or organization:

Father Ryan High School

700 Norwood Drive, Nashville, TN 37204

2. The purpose(s) for the use or disclosure is as follows: **INJURIES AND ILLNESSES RELATED TO PHYSICAL ACTIVITY**

3. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from N/A to N/A Date of Service

Date of service

* Abstract (Includes H&P, Progress notes, Procedure reports, Consult, DS, Diagnostic Testing, and all dictated reports.)

* Copy of Medical Record only

* Copy of Complete Record (medical records and financial records)

History and Physical (H&P)

* Consultation

* Summary

* Discharge summary (DS)

* Operative / Procedure Report (OP)

* Pathology Report

* Laboratory Report

* X-Ray Report

Other: **INFORMATION REGARDING SPECIFIC INJURIES I MAY INCUR DURING SPORTS PARTICIPATION**

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **June 1, 2012**. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. **Star Physical Therapy** may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I

understand that if I authorize **Star Physical Therapy** to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact **Star Physical Therapy** at 615-591-6590.

Signature of Student-Athlete

Signature of Parent/ Guardian

Date

Medical/Physical Form

To be filled out and *signed by physician* or medical staff

Athlete's Name _____ **General Examiner** _____

Height _____ Weight _____ BP _____/_____/_____ Pulse _____ Vision R 20/_____/_____ L 20/_____/_____ Corrected? Yes No
Pupils _____

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

Musculoskeletal Examination **Examiner:** _____

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

Optional Lab

Urine Sugar _____
Urine Protein _____
Urine Hematest _____

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:

C. Recommend further consultation with _____

Signature of Physician

Date