To student athletes and their parents/caregivers:

Before you can play a sport the TSSAA (Tennessee Secondary School Athletic Association) says you must get a sport's physical. This is also called a PPE (Preparticipation Physical Evaluation). The PPE promotes the health and well-being of athletes as they train and compete. It also helps keep athletes safe as they play sports. It is NOT meant to stop them from playing.

Where can you go to get a PPE? In the newest PPE guidebook, the groups below say your doctor's office or the place where you get your medical care is where you can go to get it done:

- the American Academy of Pediatrics,
- the American Academy of Family Physicians,
- the American College of Sports Medicine,
- the American Medical Society for Sports Medicine,
- the American Orthopedic Society for Sports Medicine,
- and the American Osteopathic Academy of Sports Medicine.
- It's also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations.

There are other places you can get a PPE, but **we recommend athletes get a PPE during their Well Visit at their doctor's office or School Based Health Center.** This ensures exams cover everything important about your overall health and well-being. It also limits absences from school and sports.

We encourage you to work the PPE into the routine health care you get at your doctor's office or the place where you get your medical care. If you're enrolled in TennCare your well visits are free.

Sincerely,

Tennessee Secondary School Athletic Association
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Division of TennCare

Do you have TennCare and need to know who your doctor is? You can call your MCO at:

Amerigroup: 1-800-600-4441
BlueCare: 1-800-468-9698
UnitedHealthcare: 1-800-690-1606
TennCare*Select*: 1-800-263-5479

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU *(CONTINUED)*	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name_____ First Name _____ MI _____

Sex: [ ] Male [ ] Female Grade _____ Age _____ DOB ____/____/_____

Allergies _____

Medications_____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

Emergency Contact Information

Home Address _____ (City) _____ (Zip) _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for (**athlete's name**) _____ to represent (**name of school**) _____ in athletics 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, and 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 the 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 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.***

_____ _____ _____

Signature of Athlete **Signature of Parent/Guardian** **Date**

CONSENTIMIENTO A PARTICIPAR EN ACTIVIDADES ATLETICAS Y RECIBIR CUIDADO MEDICO SI FUERA NECESASRIO

(Este Consentimiento debe ser completado por el Estudiante-Atleta y sus padres o guardianes.)

Información del Estudiante-Atleta

Apellido _____ Nombre _____ SN _____

Sexo: [ ] Varón [ ] Hembra Grado_____ Edad_____ Fecha de Nacimiento____/____/____

Alergias _____

Medicaciones _____

Seguro Médico _____ Número de la Póliza _____

Número del Grupo _____ Teléfono del Seguro _____

Información del Contacto en Caso de Emergencia

Dirección de Casa _____ (Ciudad) _____

(Código Postal) _____

Teléfono de Casa _____ Celular de la Madre o Guardian _____

Celular del Padre o Guardian _____

Nombre de la Madre o Guardian _____ Teléfono del Trabajo _____

Nombre del Padre o Guardian _____ Teléfono del Trabajo _____

Otra Persona Contacto _____

Número de Teléfono _____ Relación _____

Consentimiento Legal de los Padres o Guardianes

Yo/Nosotros damos nuestro consentimiento para que (nombre del Estudiante-Atleta)_____ pueda representar (nombre de la escuela)_____ en deportes y que yo/nosotros entendemos que esa actividad lleva la posibilidad de sufrir lesiones. Yo/Nosotros sabemos que aún con el mejor entrenamiento, los mejores artículos deportivos, y la observación estricta de las reglas, es posible sufrir lesiones. **En algunas ocasiones, estas lesiones son severas y pueden resueltar en incapacidad, parálisis, y hasta la muerte. Yo/Nosotros damos permiso a la escuela y a TSSAA, sus médicos, entrenadores atléticos, y/o técnicos médicos de emergencias a dar ayuda, tratamiento, cuidado médico o quirúrgico considerados necesarios para la salud y bienestar del Estudiante-Atleta nombrado arriba durante o como resultado de su participación en los deportes.** Al firmar este consentimiento, el Estudiante-Atleta nombrado arriba y sus padres/guardianes consienten a que los profesionales de la salud conduzcan un chequeo, examinación, y pruebas del Estudiante-Atleta durante la examinación pre-participacipatoria y a obtener la historia médica. Entendemos que los profesionales de la salud que conduzcan estas pruebas y evaluaciones van a anotar los resultados y observaciones en los formularios y records que acompañan este documento. Como padre o guardian , **yo/nosotros entendemos que somos totalmente responsables por cualquier asunto legal que pueda resultar de las acciones personales del Estudiante-Atleta nombrado arriba.**

Firma del Estudiante-Atleta Firma del Padre/Guardian Fecha