

Full Name: _____ Grade: _____ Sex: M F

DOB: ____/____/____ Age: _____ Sport(s): _____

Family/Personal Physician(s): _____ Phone: _____

INSTRUCTIONS: Circle "YES" or "NO" for each question. Please EXPLAIN all "YES" responses below--Be specific

HAVE YOU EVER:

YES NO 1. Been hospitalized? _____

YES NO 2. Had any surgery? _____

YES NO 3. Passed out or fainted during exercise? _____

YES NO 4. Become dizzy during or after exercise? _____

YES NO 5. Had chest pain during or after exercise? _____

YES NO 6. Had high blood pressure? _____

YES NO 7. Been told that you have a heart murmur? _____

YES NO 8. Had a racing heart rate or skipped heartbeats? _____

YES NO 9. Had anyone in your family die from heart-related problems or sudden death prior to age 50? _____

YES NO 10. Had a serious head injury? _____

YES NO 11. Been knocked out or unconscious? _____

YES NO 12. Had or suffered any type of seizure? _____

YES NO 13. Had a "stinger", "burner" or pinched nerve? _____

YES NO 14. Had heat or muscle cramps? _____

YES NO 15. Been treated for heat exhaustion or heat stroke? _____

YES NO 16. Been dizzy or passed out in the heat? _____

YES NO 17. Had trouble breathing or coughing during or after activity/exercise? _____

YES NO 18. Had any problems with your eyes or vision? _____

YES NO 19. Sprained, strained, dislocated or fractured a bone? (Check all that apply)

Head Neck Shoulder Elbow Forearm Wrist / hand / fingers Chest Back

Hip Thigh Knee Shin / calf Ankle Foot / toes

YES NO 20. Had or suffered from other medical conditions? (Hepatitis, Meningitis, Mononucleosis, Asthma, Epilepsy, Diabetes, etc.) _____

YES NO 21. Been advised by medical personnel not to participate in athletic-related activities? Reason: _____

YES NO 22. ***Do you have sickle cell trait, or have a family history of sickle cell trait? If "YES" to either, please explain.*** _____

DO YOU:

YES NO 23. Have any known allergies? Please list: _____

YES NO 24. Currently take any medications? Please list: _____

YES NO 25. Often tire out more quickly than your friends during exercise? _____

YES NO 26. Have any skin problems (rashes, itching, acne, etc.)? _____

YES NO 27. Wear (Check all that apply): glasses? contact lenses? protective eyewear? _____

YES NO 28. Wear or use any special braces or equipment? _____

YES NO 29. Currently have any medical problems (since your last medical evaluation)? _____

YES NO 30. Have any religious beliefs that would NOT allow you to be treated by a physician or medical facility should you become injured or seriously ill? _____

30. What was the date of your: Last tetanus shot? _____ Last measles immunization? _____

I/We hereby state that, to the best of our knowledge, the information given above is complete and accurate.

Athlete's Signature

Parent/Guardian's Signature

_____/_____/_____
Date

PRE-PARTICIPATION PHYSICAL EXAMINATION

NAME: _____

GENERAL PHYSICAL EXAMINATION

EXAM DATE: ____/____/____

Height: ____ ft. ____ in Weight: _____ Blood Pressure: ____/____ Pulse: _____

NORMAL

ABNORMAL FINDINGS

	NORMAL	ABNORMAL FINDINGS
Ears, Nose & Throat		
Chest, Heart & Lungs		
Abdominal, Genitalia & Hernia		
Skin & Lymphatic		

MUSCULOSKELETAL EXAMINATION

NORMAL

ABNORMAL FINDINGS

	NORMAL	ABNORMAL FINDINGS
Cervical Neck and Back		
Upper Extremities		
Lower Extremities		
Flexibility		

ADDITIONAL PHYSICIAN NOTES: _____

OFFICIAL RECOMMENDATION:

A. This athlete ____ **MAY** ____ **MAY NOT** compete in athletics based on information obtained from this examination

B. Prior to participation, treatment or follow-up care is recommended for: _____

_____.

C. Recommend further consultation with: _____

Printed Name of Examining/Clearing Physician: _____

Signature of Examining/Clearing Physician: _____ Date: ____/____/____

Student's Full Name: _____ DOB: ____/____/____ Age: _____

Parent/Guardian _____ Cell Phone: () _____
Names: (Father, Stepfather, etc..)

_____ Cell Phone: () _____
(Mother, Stepmother, etc..)

Home Address: _____

Home Phone: () _____

Father's Employer: _____ Work Phone: () _____

Mother's Employer: _____ Work Phone: () _____

Other Person to Contact: _____ Relationship: _____ Phone: () _____

Insurance Company Name: _____

Policyholder Name: _____ Policy/Group Number(s): _____

Known ALLERGIES: _____ Wear Contact Lenses: YES NO

Current MEDICATIONS: _____

PARENTAL CONSENT TO PARTICIPATE, ACKNOWLEDGMENT OF RISKS & MEDICAL AUTHORIZATION:

I/We hereby give consent for (student's name) _____ to represent

MEMPHIS UNIVERSITY SCHOOL in the sport(s) of: _____.

FURTHERMORE:

1. I / We hereby acknowledge an awareness that participation in secondary school athletics involves the risk of injury. I/We also understand that due to the competitive nature of secondary school athletics, injuries may occur which can result in serious physical disability, paralysis, permanent mental disability or even death. My signature below indicates that I have read and fully understand the potential catastrophic risks associated with participation in secondary school athletics.

2. Permission is hereby granted to Memphis University School and/or its authorized representatives or medical facility to proceed with any medical or minor surgical treatment, x-ray, examination or immunization deemed necessary for the well-being of the above-named student. I/We understand that in the event of a serious or life-threatening injury/illness, the attending physician (or anyone he/she may designate) will make every attempt to contact us in the most expeditious manner possible. If unable to contact either of us, **permission is hereby granted** for treatment or procedure deemed necessary for the well-being of the above named student.

3. **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION:** I hereby authorize the MUS medical staff to provide coaches of MUS with the following information regarding my son: health status, injuries sustained during participation in athletic events, injury rehabilitation progress, physical limitations, and ability to engage in sports activities. After information is released to the coaching staff(s), federal privacy laws no longer protect this information.

4. A photocopy of this sheet shall be considered as effective and valid as the original.

Parent/Guardian Signature: _____ Date: ____/____/____