PREPARTICIPATION MEDICAL EVALUATION FORM

Personal History

Name ____ Social Security # ___________________

Sex M / F Age__________ DOB ____________________Grade __________________

School ______________________________Sport(s)___________________________________

Personal Physician_______________________ Address _________________________Telephone __________

Have you ever had a preparticipation physical before? ___ Yes ___ No If yes, when/where ________________________

Please explain "Yes" answers below. **YES / NO**

1.	Have you ever been hospitalized?	1. _____ _____
2.	Have you ever had surgery?	2. _____ _____
3.	Are you presently taking any medications or pills?	3. _____ _____
4.	Do you have allergies (medicine, bees or other stinging insects?	4. _____ _____
5.	Have you ever passed out during exercise?	5. _____ _____
6.	Have you ever been dizzy during or after exercise?	6. _____ _____
7.	Have you ever had chest pain during exercise?	7. _____ _____
8.	Do you tire more quickly than your friends during exercise?	8. _____ _____
9.	Have you ever had high blood pressure?	9. _____ _____
10.	Have you ever been told that you have a heart murmur?	10. _____ _____
11.	Has anyone in your family died of heart problems or a sudden death before the age of 50?	11. _____ _____
12.	Do you have any skin problems (itching, rashes, acne)?	12. _____ _____
13.	Have you ever had a head injury?	13. _____ _____
14.	Have you ever been knocked unconscious?	14. _____ _____
15.	Have you ever had a seizure?	15. _____ _____
16.	Have you ever had a stinger, burner or pinched nerve?	16. _____ _____
17.	Have you ever had heat or muscle cramps?	17. _____ _____
18.	Have you ever been dizzy or passed out in the heat?	18. _____ _____
19.	Do you have trouble breathing or do you cough during or after activities?	19. _____ _____
20.	Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)?	20. _____ _____
21.	Have you had any problems with your eyes or vision?	21. _____ _____
22.	Do you wear glasses or contacts or protective eye wear?	22. _____ _____

23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?

_____ Head _____ Shoulder _____ Thigh _____ Neck _____ Elbow _____ Knee _____ Chest
_____ Forearm _____ Shin/Calf _____ Foot _____ Back _____ Wrist _____ Ankle _____ Hip _____ Hand

24.	Have you had any other medical problem (infectious mononucleosis, diabetes)?	24. _____ _____
25.	Have you had a medical problem since your last evaluation?	25._____ _____

26. When was your last tetanus shot? ____
27. When was your last measles shot? ____

(FEMALE ONLY)

28. When was your first menstrual period? ____
29. When was your last menstrual period? ____
30. When was the longest time between your periods last year? ____________________________

Please explain "yes" answers here:

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

___________________________ ___________________________ __________

Signature of Athlete Signature of Parent Date

Height ________________ Weight _______________ BP __________/__________ Pulse__________

Vision R 20/_____ L 20/_____ Corrected? _____ Yes _____ No Pupils __________

Musculoskeletal Examination

	Normal	Abnormal Findings
Neck / Back	____________________	___________________________
Upper Extremities	____________________	___________________________
Lower Extremities	____________________	___________________________
Flexibility	____________________	___________________________

General Examination

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

A. This individual _____ may _____ may not participate based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is recommended:

Official Recommendation

C. Recommend further consultation with

Signature of Physician: ____ Date: _____________

EMERGENCY TREATMENT

(Please Print)
LAST NAME ______________________________ FIRST NAME ______________________ MI _____

SEX: MALE _____ FEMALE _________ GRADE: ________ AGE: ________ DOB: _____________

ALLERGIES:____

STUDENTS SS #:_______________________________ INSURANCE: _________________________

General Information:

Father's Name: ____ SS#: ___________________

Work Address: ____Work Phone: _________________

Mother's Name: ____ SS#: ____________________

Work Address: ____Work Phone: _________________

Home Address: ____Home Phone: ________________

Father's Cell #: ____________________________ Mother's Cell #: ___________________________

Another Person to Contact: _____________________________Phone: _________________________

Relationship: ____

Legal/Parent Consent:

I/We hereby give consent for (participant's name) ____________________________________ to represent _______________________, 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, athletic trainers and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the participant named above. By the execution of this consent, the participant named above and his/her parents/guardian(s) do hereby consent to screening, examination, and testing of the participant 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 participant 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 Signature Parent/Guardian Signature Date

Authorization for Use or Disclosure of Protected Health Information

Patient Name: ______________________________ Social Security Number: __________________

Date of Birth: ______________________________ Phone Number: __________________________

1. I authorize Baptist Hospital to:

   ☐ Use my health information as described below; and/or

   XX Disclose my health information to the following individual or organization:

   ____

   Address: ____

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)

XX 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.___________________________

____

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 to the extent that Baptist Hospital has taken in reliance on this authorization. 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, 2006 . 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. Baptist Hospital 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 Baptist Hosptital 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 the Health Information Management Department at 615-284-8223.

______________________________________ ______________________________

Signature of Patient or Legal Representative — Date

____

If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED