



H I G H S C H O O L  
3470 RIDGECREST ROAD EXT. | JACKSON, TENNESSEE 38305 | 731.423.9086

# PHYSICAL PACKET (2023-2024)

This packet, **front and back** must be completely filled out and on record with the athletic director's office prior to any participation in tryouts, practice, or athletic events.

**Cover Page:** Write your full name in the blanks provided.

**Page 2:** Read and complete each blank. Remember to include insurance information if #2 is selected. Parent signature and date required.

**Page 3:** Read and print student name. Parent signature and date.

**Page 4:** Fill out *completely*. Parent and student sign and date.

**Page 5-6:** Read with parent.

**Page 7:** Print names at top of page. Student initials go in the left column, and parent initials go in the right column. Parent and student sign and date at bottom of page.

**Page 8:** Read with parent.

**Page 9:** Print parent/student names. Parent and student signatures and date.

**Page 10:** Complete each blank. Student and parent sign and date at bottom of the page.

**Page 11:** Print student name and date of birth at top of page. Physician must complete form and check the appropriate box at the bottom. Physician signature, address, phone, and date required.

**Athlete**

\_\_\_\_\_  
LAST NAME

\_\_\_\_\_  
FIRST NAME

\_\_\_\_\_  
MIDDLE NAME

*Copias de estos formularios están disponibles en español en la oficina del director de atletismo.*

*Copies of these forms are available in Spanish from the athletic director's office.*

*Copies of many of these forms are available online at <http://tssaa.org/physical-forms/>*

*Forms for athletes with special needs are available from the athletic director's office.*

# PERSONAL AFFIDAVIT IN LIEU OF SCHOOL INSURANCE

*All students who participate in any school sponsored athletic sport must file with the principal an affidavit form that they or their insurance company will be responsible for payment in case of injury.*

## STATE OF TENNESSEE JACKSON-MADISON COUNTY SCHOOLS

I/We \_\_\_\_\_ make oath in due form of law that I/we  
*Name of Parent/Guardian (s)*

am/are the parent(s) or guardian(s) of \_\_\_\_\_ who  
*Name of Student*

is a student at Liberty Technology Magnet High School, and that I/we hereby join in the application of said applicant:

- Circle One:**
1. to be personally
  2. to have my/our insurance company

Responsible for payment of any injury sustained at said school while participating in school-sponsored sports.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\*\*\*If number 2 was checked above, please list insurance information below:

\_\_\_\_\_  
Name of Insurance Company

Policy Number

## **STUDENT AUTHORIZATION AND DISCLOSURE OF HEALTH INFORMATION AND CONSENT TO TREAT AND CARE**

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel from Jackson-Madison County General Hospital, Sports Plus, Sports Orthopedics and Spine, Liberty Technology Magnet High School's coaching staff, and any medical physicians available at away games to release and disclose all information regarding the below-named student-athlete in regards to maintaining the well-being of said student due to injury or illness occurring during such student-athlete participation at Liberty Technology Magnet High School. This protected health information that may be disclosed includes the student's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, payment information and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic or school administrators and school officials.

I understand that my giving authorization/consent for the disclosure of the student athlete's protected health information is a condition for participation as an interscholastic athlete at Liberty Technology Magnet High School for the purpose of the undersigned student-athlete's participation in interscholastic sports. I understand that the student-athlete's protected health information is protected by the federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without wither parent/guardian authorization under HIPAA or consent under the Buckley Amendment, except in certain circumstances set forth in those laws.

I, the parent/guardian, understand that once information is disclosed per this Authorization, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I also understand that this Authorization is voluntary, that I may refuse to sign this Authorization, and that I may revoke this Authorization at any time by notifying the Athletic Director and/or Administration of Liberty Technology Magnet High School in writing.

I, the parent/guardian, recognize that as a result of the student-athlete participation in sports activities, medical treatment on an emergency basis may be necessary. I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby AUTHORIZE in advance the provision of such emergency care, including hospital care, as may be deemed necessary under the then existing circumstances, and I hereby release and indemnify Sports Plus, Sports Orthopedics and Spine, Liberty Technology Magnet High School and/or other emergency staff against all liability resulting therefore. The purpose of this release is to authorize emergency medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

I, the parent/guardian, understand that if I revoke or refuse this Authorization that the student-athlete will not receive medical attention or disclosure of information of medical physicians related to Liberty Technology Magnet High School.

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Print Student-Athlete's Name

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Signature of Parent/Legal Guardian

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Date

This Authorization expires one year from the date it is signed.

**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 Liberty Technology Magnet High 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

## CONCUSSION

### INFORMATION AND SIGNATURE FORM FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

(Adapted from CDC "Heads Up Concussion in Youth Sports")

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

**Read and keep this page.**

**Sign and return the signature page.**

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

#### Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

#### WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

| SIGNS OBSERVED BY COACHING STAFF                | SYMPTOMS REPORTED BY ATHLETES              |
|---|--|
| Appears dazed or stunned                        | Headache or "pressure" in head             |
| Is confused about assignment or position        | Nausea or vomiting                         |
| Forgets an instruction                          | Balance problems or dizziness              |
| Is unsure of game, score or opponent            | Double or blurry vision                    |
| Moves clumsily                                  | Sensitivity to light                       |
| Answers questions slowly                        | Sensitivity to noise                       |
| Loses consciousness, even briefly               | Feeling sluggish, hazy, foggy or groggy    |
| Shows mood, behavior or personality changes     | Concentration or memory problems           |
| Can't recall events <i>prior</i> to hit or fall | Confusion                                  |
| Can't recall events <i>after</i> hit or fall    | Just not "feeling right" or "feeling down" |

*\*Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training*



## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

## WHY SHOULD AN ATHLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

### Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

\* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

## Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

After reading the information sheet, I am aware of the following information:

| Student-Athlete initials |  | Parent/Legal Guardian initials |
|--------------------------|--|--------------------------------|
|                          | A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.   |                                |
|                          | A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.  |                                |
|                          | I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.  | N/A                            |
|                          | I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.  | N/A                            |
|                          | I will/my child will need written permission from a <i>health care provider*</i> to return to play or practice after a concussion.   |                                |
|                          | Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.  |                                |
|                          | After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.                         |                                |
|                          | After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away. |                                |
|                          | Sometimes repeat concussion can cause serious and long-lasting problems and even death.  |                                |
|                          | I have read the concussion symptoms on the Concussion Information Sheet.   |                                |

\* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal guardian

\_\_\_\_\_  
Date

## Sudden Cardiac Arrest Symptoms and Warning Signs

### What is Sudden Cardiac Arrest (SCA)?

SCA is a life-threatening emergency that occurs when the heart suddenly and unexpectedly stops beating. This causes blood and oxygen to stop flowing to the rest of the body. The individual will not have a pulse. It can happen without warning and can lead to death within minutes if the person does not receive immediate help. Only **1 in 10** survives SCA. If Cardiopulmonary Resuscitation (CPR) is given and an Automatic External Defibrillator (AED) is administered early, **5 in 10** could survive.



SCA is NOT a heart attack, which is caused by reduced or blocked blood flow to the heart. However, a heart attack can increase the risk for SCA.

### Watch for Warning Signs

SCA usually happens without warning. SCA can happen in young people who don't know they have a heart problem, and it may be the first sign of a heart problem. When there are warning signs, the person may experience:



If any of these warning signs are present, it's important to talk with a health care provider. There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops due to SCA, blood stops flowing to the brain and other body organs. Death or permanent brain damage can occur in minutes.

### Electrocardiogram (EKG) Testing

EKG is a noninvasive, quick, and painless test that looks at the heart's electrical activity. Small electrodes attached to the skin of the arms, legs, and chest capture the heartbeat as it moves through the heart. An EKG can detect some heart problems that may lead to an increased risk of SCA. Routine EKG testing is not currently recommended by national medical organizations, such as the American Academy of Pediatrics and the American College of Cardiology, unless the pre-participation physical exam reveals an indication for this test. The student or parent may request, from the student's health care provider, an EKG be administered in addition to the student's pre-participation physical exam, at a cost to be incurred by the student or the student's parent.



While rare, SCA is the #1 medical cause of death in young athletes.

### Limitations of EKG Testing

- An EKG may be expensive and cannot detect all conditions that predispose an individual to SCA.



- False positives (abnormalities identified during EKG testing that turn out to have no medical significance) may lead to unnecessary stress, additional testing, and unnecessary restriction from athletic participation.
- Accurate EKG interpretation requires adequate training.

*I have reviewed and understand the symptoms and warning signs of SCA.*

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Signature of Student-Athlete

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Print Student-Athlete's Name

---

Date

---

Signature of Parent/Guardian

---

Print Parent/Guardian's Name

---

Date

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

| GENERAL QUESTIONS  | Yes | No |
|--|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   |     |    |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections<br>Other: _____   |     |    |
| 3. Have you ever spent the night in the hospital?  |     |    |
| 4. Have you ever had surgery?  |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU   | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise?   |     |    |
| 6. Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?   |     |    |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise?  |     |    |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection<br><input type="checkbox"/> Kawasaki disease Other: _____ |     |    |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)   |     |    |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise?   |     |    |
| 11. Have you ever had an unexplained seizure?  |     |    |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise?   |     |    |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY   | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?   |     |    |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  |     |    |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  |     |    |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  |     |    |
| BONE AND JOINT QUESTIONS   | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?   |     |    |
| 18. Have you ever had any broken or fractured bones or dislocated joints?  |     |    |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?   |     |    |
| 20. Have you ever had a stress fracture?   |     |    |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)   |     |    |
| 22. Do you regularly use a brace, orthosis, or other assistive device?   |     |    |
| 23. Do you have a bone, muscle, or joint injury that bothers you?  |     |    |
| 24. Do any of your joints become painful, swollen, feel warm, or look red?   |     |    |
| 25. Do you have any history of juvenile arthritis or connective tissue disease?  |     |    |

| MEDICAL QUESTIONS   | Yes | No |
|---|-----|----|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                    |     |    |
| 27. Have you ever used an inhaler or taken asthma medicine?   |     |    |
| 28. Is there anyone in your family who has asthma?  |     |    |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? |     |    |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area?  |     |    |
| 31. Have you had infectious mononucleosis (mono) within the last month?   |     |    |
| 32. Do you have any rashes, pressure sores, or other skin problems?   |     |    |
| 33. Have you had a herpes or MRSA skin infection?   |     |    |
| 34. Have you ever had a head injury or concussion?  |     |    |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?      |     |    |
| 36. Do you have a history of seizure disorder?  |     |    |
| 37. Do you have headaches with exercise?  |     |    |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?              |     |    |
| 39. Have you ever been unable to move your arms or legs after being hit or falling?                                 |     |    |
| 40. Have you ever become ill while exercising in the heat?  |     |    |
| 41. Do you get frequent muscle cramps when exercising?  |     |    |
| 42. Do you or someone in your family have sickle cell trait or disease?   |     |    |
| 43. Have you had any problems with your eyes or vision?   |     |    |
| 44. Have you had any eye injuries?  |     |    |
| 45. Do you wear glasses or contact lenses?  |     |    |
| 46. Do you wear protective eyewear, such as goggles or a face shield?   |     |    |
| 47. Do you worry about your weight?   |     |    |
| 48. Are you trying to or has anyone recommended that you gain or lose weight?                                       |     |    |
| 49. Are you on a special diet or do you avoid certain types of foods?   |     |    |
| 50. Have you ever had an eating disorder?   |     |    |
| 51. Do you have any concerns that you would like to discuss with a doctor?  |     |    |
| FEMALES ONLY  |     |    |
| 52. Have you ever had a menstrual period?   |     |    |
| 53. How old were you when you had your first menstrual period?  |     |    |
| 54. How many periods have you had in the last 12 months?  |     |    |

Explain "yes" answers here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

| EXAMINATION   |        |   |   |
|---|--------|---|---|
| Height  | Weight | <input type="checkbox"/> Male <input type="checkbox"/> Female |   |
| BP  | /      | (   | /   |
| Pulse   |        | Vision R  | L   |
|   |        | 20'   | 20'   |
|   |        | Corrected   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <b>MEDICAL</b>  |        | <b>NORMAL</b>   | <b>ABNORMAL FINDINGS</b>                              |
| Appearance<br>• Marfan stigmata (scoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperflexity, myopia, MVP, aortic insufficiency) |        |   |   |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing  |        |   |   |
| Lymph nodes   |        |   |   |
| Heart*<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI)   |        |   |   |
| Pulses<br>• Simultaneous femoral and radial pulses  |        |   |   |
| Lungs   |        |   |   |
| Abdomen   |        |   |   |
| Genitourinary (males only)  |        |   |   |
| Skin<br>• HSV lesions suggestive of MRSA, tinea corporis  |        |   |   |
| Neurologic*   |        |   |   |
| <b>MUSCULOSKELETAL</b>  |        |   |   |
| Neck  |        |   |   |
| Back  |        |   |   |
| Shoulder/arm  |        |   |   |
| Elbow/forearm   |        |   |   |
| Wrist/hand/fingers  |        |   |   |
| Hip/thigh   |        |   |   |
| Knee  |        |   |   |
| Leg/ankle   |        |   |   |
| Foot/toes   |        |   |   |
| Functional<br>• Duck-walk, single leg hop   |        |   |   |

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

\*Consider SU exam if in private setting. Having third party present is recommended.

\*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO