# 2022-2023
# TSSAA SPORTS PHYSICALS

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In Affiliation with

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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

**This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.**

**Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.**

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

## 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): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots

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: _____

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**This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.**

**Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.**

# PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)
# 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 | | |
| **COVID-19 VACCINE** | | |
| Previously received COVID-19 vaccine: ☐ Y ☐ N<br>Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin<br>• 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<br>• 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

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## 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: _____

_____

_____

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# 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

**Este formulario debe colocarse en el expediente médico del atleta y no debe compartirse con escuelas u organizaciones deportivas. El formulario de elegibilidad médica es el único formulario que debe enviarse a una escuela u organización deportiva.**

**Aviso legal: Los atletas que tengan una evaluación física de preparticipación vigente en el archivo (según los lineamientos generales estatales y locales) no necesitan completar otro formulario de antecedentes.**

## EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (orientación provisional)

## FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifica? (F, M u otro): _____

¿Ha tenido COVID-19? (elija una opción) ☐ Sí ☐ No

¿Ha recibido la vacuna contra el COVID-19? (elija una opción): ☐ Sí ☐ No Si la respuesta es sí, usted recibió: ☐ Una dosis ☐ Dos dosis

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos).

_____

_____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

*Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)*

| | Ningún día | Varios días | Más de la mitad de los días | Casi todos los días |
|---|---|---|---|---|
| Se siente nervioso, ansioso o inquieto | 0 | 1 | 2 | 3 |
| No es capaz de detener o controlar la preocupación | 0 | 1 | 2 | 3 |
| Siente poco interés o satisfacción por hacer cosas | 0 | 1 | 2 | 3 |
| Se siente triste, deprimido o desesperado | 0 | 1 | 2 | 3 |

(Una suma ≥3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

| **PREGUNTAS GENERALES (Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).** | **Sí** | **No** |
|---|---|---|
| 1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos? | | |
| 2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo? | | |
| 3. ¿Padece algún problema médico o enfermedad reciente? | | |
| **PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR** | **Sí** | **No** |
| 4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio? | | |

| **PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (*CONTINUACIÓN*)** | **Sí** | **No** |
|---|---|---|
| 5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio? | | |
| 6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio? | | |
| 7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos? | | |
| 8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía. | | |
| 9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos? | | |
| 10. ¿Alguna vez tuvo convulsiones? | | |

| PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA | Sí | No |
|---|---|---|
| 11. ¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicables)? | | |
| 12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)? | | |
| 13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años? | | |
| **PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES** | **Sí** | **No** |
| 14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego? | | |
| 15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia? | | |
| **PREGUNTAS SOBRE CONDICIONES MÉDICAS** | **Sí** | **No** |
| 16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio? | | |
| 17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano? | | |
| 18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal? | | |
| 19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)? | | |

| PREGUNTAS SOBRE CONDICIONES MÉDICAS (*CONTINUACIÓN*) | Sí | No |
|---|---|---|
| 20. ¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria? | | |
| 21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída? | | |
| 22. ¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor? | | |
| 23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica? | | |
| 24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión? | | |
| 25. ¿Le preocupa su peso? | | |
| 26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso? | | |
| 27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos? | | |
| 28. ¿Alguna vez sufrió un desorden alimenticio? | | |
| **ÚNICAMENTE MUJERES** | **Sí** | **No** |
| 29. ¿Ha tenido al menos un periodo menstrual? | | |
| 30. ¿A los cuántos años tuvo su primer periodo menstrual? | | |
| 31. ¿Cuándo fue su periodo menstrual más reciente? | | |
| 32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses? | | |

**Proporcione una explicación aquí para las preguntas en las que contestó "Sí".**

_____

_____

_____

_____

_____

_____

_____

**Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.**

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____

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