

TMA/TSSAA Pre-participation Medical Evaluation Form

Name _____ Sex _____ Age _____ DOB _____
 Grade _____ Sports _____
 School _____
 Physician(s) _____

Have you ever had a pre-participation physical before? ___ Yes ___ NO If so, When/Where _____

Please explain “yes answers below”

Yes NO

- | | | |
|--|-----|-----|
| 1. Have you ever been hospitalized? | ___ | ___ |
| Have you ever had surgery? | ___ | ___ |
| 2. Are you presently taking any medications or pills? | ___ | ___ |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? | ___ | ___ |
| 4. Have you ever passed out during exercise? | ___ | ___ |
| Have you ever been dizzy during or after exercise? | ___ | ___ |
| Have you ever had chest pains during or after exercise? | ___ | ___ |
| Do you tire more quickly than your friends during exercise? | ___ | ___ |
| Have you ever had high blood pressure? | ___ | ___ |
| Have you ever been told that you have a heart murmur? | ___ | ___ |
| Have you ever had a racing of your heart or skipped heartbeats? | ___ | ___ |
| Has anyone in your family died of heart problems or a sudden death before the age of 50? | ___ | ___ |
| 5. Do you have any skin problems (itching, rashes, acne)? | ___ | ___ |
| 6. Have you ever had a head injury? | ___ | ___ |
| Have you ever had a seizure? | ___ | ___ |
| Have you ever had a stinger, burner or pinched nerve? | ___ | ___ |
| 7. Have you ever had heat or muscle cramps? | ___ | ___ |
| Have you ever been dizzy or passed out in the heat? | ___ | ___ |
| 8. Do you have trouble breathing or do you cough during or after activities? | ___ | ___ |
| 9. Do you use any special equipment (pads, braces, neck roll, mouth/eye guard)? | ___ | ___ |
| 10. Have you had any problems with your eyes or vision? | ___ | ___ |
| Do you wear glasses or contacts or protective eyewear? | ___ | ___ |
| 11. 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 ___ Back ___ Wrist ___ Ankle ___ Hip ___ Hand ___ Foot | | |
| 12. Have you ever had any other medical problems (infectious mononucleosis, diabetes)? | ___ | ___ |
| 13. Have you had a medical problem since your last evaluation? | ___ | ___ |
| 14. When was your last tetanus shot? _____ | | |
| When was your last measles immunization? _____ | | |
| 15. When was your first menstrual period? _____ | | |
| When was your last menstrual period? _____ | | |
| When was the longest time between your periods last year? _____ | | |

Please explain “yes” answers here:

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

Signature of Athlete	Signature of Parent/Guardian	Date
Signature of Coach	School	