

KNOX COUNTY SCHOOLS
PHYSICAL EXAMINATION AND SPORTS MEDICAL PERMISSION FORM

I/We hereby give consent for (student's name) _____ to represent (name of school) _____ in the sport(s) of _____ realizing that such activity involves the potential for injury. I/We acknowledge that even with the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be severe and result in total disability, paralysis, or even death.

I/We further grant permission to (school) _____, its physicians and/or Athletic Trainers to render aid, treatment, medical, or surgical care deemed reasonably necessary to protect the health and well being of the above individual.

I/We further release (school) _____, its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept full responsibility for any damages or injuries sustained as a result of participation in the sport(s) or extracurricular activity named above.

Student _____ Parent/Guardian(s) _____

Date _____

Personal History

Name _____	Sex _____	Age _____	DOB _____
Grade _____	Social Security Number _____		
School _____			
Personal Physician(s) _____	Address _____	Telephone _____	

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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies (medicine, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain 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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5. Do you have any skin problems (itching, rashes, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a head injury? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
8. Do you have trouble breathing or do you cough during or after activities?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand <input type="checkbox"/> Foot	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had a medical problem since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
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? _____ What 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 _____
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General Physical Examination

Examiner _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected? yes no Pupils _____

Normal

Abnormal Findings

Ears, nose, throat		
Heart		
Chest/lungs		
Skin/Lymphatics		
Abdominals		
Genitalia/Hernia		

Musculoskeletal Examination

Examiner _____

Normal

Abnormal Findings

Neck/Back		
Upper Extremities		
Lower Extremities		
Flexibility		

Optional Lab

Urine Sugar _____

Urine Protein _____

Urine Hematest _____

Official Recommendation

A. This athlete may may not compete in athletics based on the data gathered from this exam.

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

C. Recommended further consultation with _____

Signature of Physician _____ Date _____

COACH'S ACKNOWLEDGMENT

I have reviewed all the information included in the medical history and examination and understand all restrictions (if any) that are to be observed by this athlete and acknowledge the same.

Coach's Signature _____ Date _____