

## **Instructions for Physicals at Personal Physician**

*The following items are included in this packet:*

1. Permission Form to participate in sports at St. Benedict at Auburndale.
2. **TSSAA Medical Evaluation Form for Personal Physician**
3. TSSAA pre-participation medical evaluation form.
4. Emergency Treatment Form.
5. The HIPPA form. This form must be signed in order for the on-campus trainer to be able to discuss the physical condition of the athletes with their coaches.
6. **PLEASE TURN IN ALL PHYSICALS TO THE ATHLETIC DEPARTMENT – NOT THE COACH. THIS WILL PREVENT LOST PHYSICALS DURING THE YEAR.**

# PERMISSION FORM FOR SPORT'S PARTICIPATION

STUDENT'S NAME (please print): \_\_\_\_\_

I hereby give my consent for the above named student to represent St. Benedict at Auburndale in school sponsored sporting events.

I give my permission for the above named student to participate in high school sports, realizing that such activities involve the potential for injury. I 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 occasion these injuries can be severe and result in total disability, paralysis, or even death.

I hereby acknowledge that St. Benedict at Auburndale has a basic catastrophe accident medical policy (NFSESA Liability Policy with Lifetime Medical & Disability Settlement Option). I acknowledge that I have primary medical insurance on the above student with medical benefits (\$00.01 through \$10,000).

I am aware that high school sporting events will require off campus travel and I hereby give my permission for my son/daughter to travel to all off campus meets, either by bus or *any approved* means of transportation. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I believe that the subject of this release is physically and mentally capable of taking reasonable precautions to protect his/her own safety and has the maturity and judgment not to put themselves or others in dangerous situations. I agree to not hold the Catholic Diocese of Memphis, St. Benedict at Auburndale, its leaders, employees, or volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject.

As the parent/guardian of \_\_\_\_\_, I have reviewed the information and I request that the subject of this release be allowed to participate in all the planned activities except \_\_\_\_\_. (Insert NA if there are no exceptions.)

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

## Volunteer Driver Form (optional)

I give my consent for my son/daughter to drive our family automobile to off campus sporting events whenever deemed necessary.

Student Driver: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Auto Insurance Company Name: \_\_\_\_\_ Agent Name: \_\_\_\_\_

Have you had citations or convictions to any of the following in the last three years?

- |   |                |
|---|----------------|
| 1. Driving under the influence of alcohol or drugs              | Yes ___ No ___ |
| 2. Hit and Run  | Yes ___ No ___ |
| 3. Failure to report an accident                                | Yes ___ No ___ |
| 4. Negligent homicide arising out of the use of a motor vehicle | Yes ___ No ___ |
| 5. Using a motor vehicle for the commission of a felony         | Yes ___ No ___ |
| 6. Permitting an unlicensed person to drive                     | Yes ___ No ___ |
| 7. Reckless Driving   | Yes ___ No ___ |
| 8. Speed Contest  | Yes ___ No ___ |

In order to provide for the safety of our students, other members of the parish, and those we serve, we cannot use your services as volunteer driver if you do not have a current valid driver's license and insurance on your vehicle. If you answered yes to any of the questions concerning the citations and convictions, we must also disqualify you as a volunteer driver. It is expected that all our volunteer drivers will abide by the Tennessee Seat Belt Law. Please be aware that as a volunteer driver, your insurance is primary. There is a policy that would offer additional liability should a claim exceed the limits of your policy.

\_\_\_\_\_  
Date Signature of Student Signature of Parent/Guardian

**TSSAA Medical Evaluation Form for Personal Physician**

**Name of Athlete** \_\_\_\_\_

**General Physical Examination**

Examiner: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected?  yes  no Pupils \_\_\_\_\_

	Normal	Abnormal Findings
Ear, nose, throat		
Heart		
Chest/lungs		
Skin/Lymphatic		
Abdominal		
Genitalia/Hernia		

Examiner: \_\_\_\_\_

**Musculoskeletal Examination**

	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. Recommend further consultation with \_\_\_\_\_

Signature of physician \_\_\_\_\_ Date: \_\_\_\_\_

## TSSAA PREPARTICIPATION MEDICAL EVALUATION FORM

### Personal History

Name	Sex	Age	DOB
Grade	Sport(s)		
School			

Personal Physician	Address	Telephone
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Have you ever had a pre-participation physical before?  Yes  No If yes, 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 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 pain/discomfort during exercise? Have you had excessive, unexpected or unexplained shortness of breath during 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? Has anyone in your family died of heart problems or a sudden death before the age of 50? Has anyone in your family developed a disability from heart disease 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 been knocked unconscious? 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 role, mouth guard, eye guard)?	_____	_____
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	_____	_____
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      _____ Foot _____ Back      _____ Wrist      _____ Ankle      _____ Hip      _____ Hand	_____	_____
12. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	_____	_____
13. Have you ever had a medical problem since your last evaluation?	_____	_____
14. Have you lost/gained more than 15 lbs over the last 6 months?	_____	_____
15. When was your last tetanus shot? When was your last measles shot?	_____	_____
16. 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, and with my signature give Campbell Clinic permission to perform pre-participation physical on my child.

Signature of Athlete	Signature of Parent/Guardian	Date
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## EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school or it's representative, this will allow the hospital to treat the injury.

### I. EMERGENCY INFORMATION

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's Name: \_\_\_\_\_

Father's SS#: \_\_\_\_\_ Mother's SS#: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Another Person to Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Policy and Group Numbers: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Consent Statement: Authorizing Treatment

Parent's Signature: \_\_\_\_\_ Student's

Signature (if over age 18): \_\_\_\_\_

### II. PARENT'S CONSENT FOR ATHLETIC PARTICIPATION

I hereby give my consent for \_\_\_\_\_ to represent

(Name of Student)

\_\_\_\_\_ in the sport of \_\_\_\_\_.

(Name of School)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Student-Athlete Authorization  
For  
Disclosure of Protected Health Information**

I hereby authorize the physicians, athletic trainers, physical therapists and sports medicine personnel representing Campbell Clinic to disclose protected health information regarding any injury or illness affecting the student-athlete's training for and participation in athletics at St. Benedict at Auburndale High School. Campbell Clinic is authorized to disclose this protected health information to any coach, the athletic director, or any school official in connection with his/her participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be disclosed to other health care providers within the Campbell Clinic system; to St. Benedict at Auburndale High School Administrators; and to officials of the Tennessee Secondary School Athletic Association.

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_,  
(name of parent/guardian) (name of student)

understand that parent/legal guardian authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at St. Benedict at Auburndale High School and for care during interscholastic athletics. I understand that my child's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). This protected health information may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing Campbell Clinic. If authorization or consent is revoked, it will not have any effect on the actions Campbell Clinic personnel took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent is enacted on the date of signature and expires on May 31, 2010. Campbell Clinic will not condition your treatment on the signing of an authorization, except for any possible research-related treatment.

**REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS**

\_\_\_\_\_  
Print Student-Athlete's Name

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

\_\_\_\_\_  
Date