

PRE-PARTICIPATION MEDICAL EVALUATION FORM

*Entire Page To Be Completed By Patient

Personal History

Athlete Name _____ Grade (2009-2010) _____

School (2009-2010) _____ Sport(s) _____

Physician _____ Address _____ Phone _____

Sex M / F Age _____ DOB _____ Social Security # _____

Have you every 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? _____
- 2. Have you ever had surgery? _____
- 3. Are you presently taking any medications or pills? _____
- 4. Do you have allergies (medicine, bees or other stinging insects?) _____
- 5. Have you ever passed out during exercise? _____
- 6. Have you ever been dizzy during or after exercise? _____
- 7. Have you ever had chest pain during exercise? _____
- 8. Do you tire more quickly than your friends during exercise? _____
- 9. Have you ever had high blood pressure? _____
- 10. Have you ever been told that you have a heart murmur? _____
- 11. Has anyone in your family died of heart problems or a sudden death before the age of 50? _____
- 12. Do you have any skin problems (itching, rashes, acne?) _____
- 13. Have you ever had a head injury? _____
- 14. Have you ever been knocked unconscious? _____
- 15. Have you ever had a seizure? _____
- 16. Have you ever had a stinger, burner, or pinched nerve? _____
- 17. Have you ever had heat or muscle cramps? _____
- 18. Have you ever been dizzy or passed out in the heat? _____
- 19. Do you have trouble breathing or do you cough during or after activities? _____
- 20. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard?) _____
- 21. Have you had any problems with your eyes or vision? _____
- 22. Do you wear glasses or contacts or protective eye wear? _____
- 23. 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
- 24. Have you ever had any other medical problem (infectious mononucleosis, diabetes?) _____
- 25. Have you ever had a medical problem since your last evaluation? _____
- 26. When was your last tetanus shot? _____
- 27. When was your last measles shot? _____

FEMALE ONLY

- 28. When was your first menstrual period? _____
- 29. When was your last menstrual period? _____
- 30. 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

*Athlete Name _____

*School (2009-2010) _____

Information below is to be completed by medical staff only.

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected Yes / No Pupils _____

Musculoskeletal Examination

Examiner: _____

Been to Physician in past 2 years for muscle, joint, or bone pain? [] No [] Yes: _____

	Normal	Abnormal Findings
Neck/Back	_____	_____
Upper Extremities	_____	_____
Lower Extremities	_____	_____
General Strength	_____	_____
General Flexibility	_____	_____

General Examination

Examiner: _____

	Normal	Abnormal Findings
Ears, Nose, Throat	_____	_____
Heart	_____	_____
Chest/Lungs	_____	_____
Skin/Lymphatic	_____	_____
Abdominal	_____	_____
Genitalia/Hernia	_____	_____

General Notes\Other:

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 / required** :

C. Recommend further consultation with _____

Physician (Print) _____ (Sign) _____ **Date** _____

EMERGENCY TREATMENT

*Entire Page Completed By Patient

Athlete Information

Last Name _____ First Name _____ MI _____

Sex: M / F Grade (2009-2010) _____ Age _____ DOB _____

Allergies _____

Athlete's SSN _____ Insurance _____

Policy Number _____ Group Number _____

Insurance Authorization\Phone Number _____

Emergency Contact Information

Home Address _____

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 2009-2010)** _____ 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, 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. 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

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

1. I authorize Baptist Hospital to:

Use my health information as described below; and/or

Disclose my health information to the following individual or organization:

School: _____ ; Baptist Sports Medicine & Affiliated Providers

Address: _____

2. The purpose(s) for the use or disclosure is as follows: _____

Orthopedic\ Sport Related Injury & Illness

3. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from

May 1 2009

August 1 2010

Date of Service

Date of Service

Abstract
(Includes H&P, Progress notes, Procedure reports, Consult, DS,
Diagnostic Testing, and all dictated reports.)

Summary
 Discharge Summary (DS)
 Operative / Procedure Report (OP)

Copy of Medical Record only
 Copy of Complete Record (medical records and financial records)

Pathology Report
 Laboratory Report
 X-Ray Report

History and Physical (H&P)

Consultation

Other: **Information regarding specific injuries I may occur related to sports participation;**

Prior orthopedic injury that would affect current participation in sports.

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that my revocation will not apply to the extent that Baptist Hospital has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **August 1, 2010**. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Baptist Hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize Baptist Hospital to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 615-284-8223. **PARENT SIGNATURE REQUIRED IF UNDER 18**

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED



AUC24000

REV - 03/19/07 Form # AUC24002

**Baptist Sports Medicine
BAPTIST HOSPITAL
Authorization for
Disclosure of PHI**

Permanent Chart Document

PATIENT LABEL