



Dear Parents/Guardians,

On Saturday, May 16<sup>th</sup> Sumner Sports Medicine will be having its annual Sports Physicals for the 2009-2010 school year. There is **no cost** to you for this service.

We will be hosting the physicals for Sumner County at **Sumner Station** just off Vietnam Veterans Bypass/Highway 386. Take Exit 12/Big Station Camp Boulevard, turn right onto Big Station Camp Boulevard, and turn left into Sumner Station. Our scheduled start time is 11:00 am. Our student-athletes will report to the check-in desk as you walk in through the glass doors and proceed to the gym area. They must be present with their physical forms in hand and completed by their parent/guardian.

It is required that all athletes have a physical each year to remain eligible for competition. We encourage all athletes to attend, as this will help ensure that there is no delay for their participation in Station Camp High School athletics. At least one coach from every team will be present during Station Camp High School's scheduled time.

Your child will be evaluated by medical personnel for a pre-participation exam. This exam is intended to identify and evaluate medical conditions that may result in injury or illness to your child or others. It is not intended to replace a complete annual physical recommended for all adolescents and should not be viewed as a substitute. It is not intended to screen for all conditions your child may have and is not a warranty of fitness to participate in the sport/activity. The physician performing this pre-participation exam is an independent contractor and is not employee or agent of Sumner Regional Medical Center. In addition, this exam is not intended to interfere with any patient/physician relationship that currently exists.

The forms are designed to help physicians and other medical personnel evaluate, process and report your son or daughter's medical clearance back to their school. It is also accompanied by Sumner County Board of Education and Station Camp High School forms necessary for participation in interscholastic athletics.

As an additional measure to ensure a smooth day, I have included a packet that each athlete must bring to the Sports Physical. This is to be filled out and signed by parent/guardians. For the athletes who forget or lose the packet, more are available on site or can be downloaded at [www.sch.sumnerschools.org/](http://www.sch.sumnerschools.org/).

BISON Pride,

**M. Trent**, M.Ed., ATC, LAT

Matt Trent, M.Ed., ATC, LAT  
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Sumner Sports Medicine  
Certified Athletic Trainer: Station Camp HS  
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**PREPARTICIPATION EVALUATION**

**EMERGENCY TREATMENT FORM**

To All Parents/Guardians:

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, this will allow the hospital to treat the injury.

**EMERGENCY INFORMATION**

Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_ 2009-2010 Grade: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

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

Home Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

List Emergency Medical Conditions: (Asthma, Diabetes, Seizures, etc.) \_\_\_\_\_

**I. Consent Statement: Authorizing Treatment**

I hereby give my consent for (student-athlete's name) \_\_\_\_\_ to be treated in the event of an injury/illness.

Parent/Guardian Signature: \_\_\_\_\_

**II. Consent Statement: Representing School**

I hereby give my consent for (student's name) \_\_\_\_\_ to represent

Station Camp High School in the sport of \_\_\_\_\_.

Parent/Guardian Signature: \_\_\_\_\_



*\*THIS FORM **MUST** BE COMPLETED BY A PARENT OR GUARDIAN!*

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

Sport(s): \_\_\_\_\_

MEDICAL HISTORY FORM	Yes	No	If Yes, Please Explain
1. Have you ever had a sports physical before?			
2. Have you ever been denied or restricted by a doctor for participation in sports?			
3. Have you had a medical illness or injury since your physical?			
4. Do you have an ongoing chronic illness? (Please list if yes)			
5. Have you ever been hospitalized?			
6. Have you ever had surgery?			
7. Are you presently taking any prescription or non-prescription medications?			
8. Do you have any allergies (medicine, bees, or other stinging insects)?			
9. Have you ever passed out during or after exercise?			
10. Have you ever been dizzy during or after exercise?			
11. Have you ever had chest pain, discomfort, or shortness of breath during exercise?			
12. Do you have trouble breathing or do you cough during or after activities?			
13. Do you get tired more quickly than your friends do during exercise?			
14. Have you ever had racing of your heart or skipped heartbeats during exercise?			
15. Have you ever had high blood pressure or high cholesterol?			
16. Have you ever been told you have a heart murmur or heart infection?			
17. Has a doctor ever ordered a test for your heart? (Ex: ECG, echocardiogram)			
18. Has anyone in your family died for no apparent reason?			
19. Has any family member/relative died of heart problems or of sudden death before age 50?			
20. Do you know of any heart conditions, sudden cardiac events in family members/relatives?			
21. Have you had a severe viral infection (ex: Myocarditis, Mononucleosis) within last month?			
22. Were you born without or are you missing any organs?			
23. Do you or a member of your family have the sickle cell trait or disease?			
24. Do you have any skin problems? (itching, rashes, acne)			
25. Have you ever had a head injury or concussion? (If so, how many, when, & severity?)			
26. Have you ever had a seizure?			
27. Do you have frequent or severe headaches with exercise?			
28. Have you ever become unconscious?			
29. Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
30. Have you ever lost feeling in your arms or legs?			
31. Have you ever had a stinger, burner, or pinched nerve?			
32. Do you have a problem with your neck or spine?			
33. Have you ever become ill from exercising in the heat?			
34. Have you ever had heat or muscle cramps?			
35. Have you ever been dizzy or passed out in the heat?			
36. Do you have asthma? If yes, how do you treat it?			
37. Do you have seasonal allergies that require medical treatment?			
38. Do you use special equipment (pads, sports brace, neck roll, mouthguard, eye guard)?			
39. Have you had any problems with your eyes or vision?			
40. Do you wear glasses, contacts, or protective eyewear?			
41. Have you ever had a sprain, strain, or swelling after an injury?			
42. Have you ever broken or fractured any bones or dislocated any joints?			
43. Have you ever had a stress fracture? If yes, where?			
44. Do you have pain or swelling in any muscle(s), tendon(s), bone(s), or joints? Please list.			
45. Are you happy with your weight?			
46. Are you trying to gain or lose weight?			
47. Has anyone recommended you change your weight or eating habits?			
48. Do you limit or carefully control what you eat?			
49. Do you have any concerns that you would like to discuss with a doctor?			

NAME: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

VISION: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ CORRECTED: Y N If Yes, Glasses \_\_\_\_\_ Contacts \_\_\_\_\_ PUPILS: EQUAL \_\_\_\_\_ UNEQUAL \_\_\_\_\_

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

Up to date \_\_\_\_\_ Not up to date \_\_\_\_\_ Specify \_\_\_\_\_

**Follow-Up Questions on More Sensitive Issues**

1. Do you feel stressed out or under a lot of pressure? ..... Y N
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?..... Y N
3. Do you feel safe? ..... Y N
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? ..... Y N
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?..... Y N
6. During the past 30 days, have you had at least 1 drink of alcohol? ..... Y N
7. Have you ever taken steroid pills or shots without a doctor's prescription? ..... Y N
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? ..... Y N
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. .... Y N

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			

\*Multiple-examiner set-up only. \*\*Having a third party present is recommended for the genitourinary examination.

\_\_\_\_\_ Cleared without restriction

\_\_\_\_\_ Not cleared for \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of physician: \_\_\_\_\_, MD or DO

**PROTECTED HEALTH INFORMATION AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize any medical provider associated with **Station Camp High School**, specifically Sumner Regional Medical Center and Sumner Sports Medicine to use and/or disclose my child's clearance and health recommendations to the athletic director, coaches and medical personnel at **Station Camp High School** to inform them of their health status for the participation in athletic or activities. I understand my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

**AUTHORIZATION FOR PERFORMANCE OF MEDICAL SCREENING**

To Parent/Guardian:

Your child is to be evaluated by medical personnel for a pre-participation exam. This exam is intended to identify and evaluate medical conditions that may result in injury or illness to your child or others. It is not intended to replace the complete annual physical recommended for all adolescents and should not be viewed as a substitute. It is not intended to screen for all conditions your child may have and is not a warranty of fitness to participate in the sport/activity. Some of the practitioners treating your child are the employees and agents of Family Wellness Group of Middle Tennessee, LLC, an affiliate of Sumner Regional Health Systems, Inc. However, some practitioners are independent contractors, and as such, have no employment or agency relationship with Sumner Regional Health Systems, Inc. This exam is not intended to interfere with any patient/physician relationship that currently exists. This form is designed to help physicians and other medical personnel evaluate, process, and report your child's medical clearance back to their school.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**LEGAL MEDICAL CONSENT**

I/WE hereby give consent for (student-athlete's name) \_\_\_\_\_ to represent **Station Camp High School** in the sport(s) of \_\_\_\_\_; realizing that such activity involves the potential for injury. I/WE acknowledge that even 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.

\_\_\_\_\_ Initials

I/WE further grant permission to **Station Camp High School** its physicians and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the above individual. Furthermore, I hold harmless **Station Camp High School** and **Sumner Regional Health Systems** its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept the full responsibility to any and all damages or injuries sustained as a result of participation in the sport(s) or extracurricular activities named above.

\_\_\_\_\_ Initials

I understand the above statements and consent for my child to participate in athletics at **Station Camp High School**.

Parent/Guardian Signature: \_\_\_\_\_

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

Station Camp High School 2009-2010