

# TSSAA Preparticipation Evaluation Physical Examination Form



931.381.BONE (2663) | 800.552.BONE (2663) | FAX 931.380.0513  
1050 N. James Campbell Blvd., Suite 200 | Columbia, TN 38401

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

% Body Fat (OPT) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ) \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected  Yes  No Pupils  Equal  Unequal

| Medical                      | Normal | Abnormal Findings | Initials* |
|------------------------------|--------|-------------------|-----------|
| Appearance                   |        |                   |           |
| Eyes/ears/nose/throat        |        |                   |           |
| Hearing                      |        |                   |           |
| Lymph nodes                  |        |                   |           |
| Heart                        |        |                   |           |
| Murmurs                      |        |                   |           |
| Pulses                       |        |                   |           |
| Lungs                        |        |                   |           |
| Abdomen                      |        |                   |           |
| Genitourinary (males only)** |        |                   |           |
| <b>Musculoskeletal</b>       |        |                   |           |
| Neck                         |        |                   |           |
| Back                         |        |                   |           |
| Shoulder/arm                 |        |                   |           |
| Elbows/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  Cleared with recommendations for further evaluation or treatment for:

\_\_\_\_\_

\_\_\_\_\_

Not cleared for  All sports  Certain sports Reason:

Recommendations \_\_\_\_\_

### Emergency Information

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_ MD or DO