TAPPS PREPARTICIPATION PHYSICAL EVALUATION

STUDENT'S FULL NAME: _____ **GRADE LEVEL:** _____

GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** ____/____/_____

HEIGHT: ____feet _____inches **WEIGHT:** _____ **% BODY FAT:** _____%

PULSE: _____ **BLOOD PRESSURE:** _____/_____ **BRACHIAL BP WHILE SITTING:** ___/ ___, ___ / ___

VISION: R 20/____ L 20/____ **CORRECTED:** Y N **PUPILS:** Equal____ Unequal____

In keeping with the requirements of the Texas Association of Private and Parochial Schools (TAPPS), the physical examination form must be completed prior entrance to high school and prior to athletic participation each year. The form is good for one year from the date of physician signature shown below.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart – Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – Lower Extremity Pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hyper mobility, or scoliosis			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS***
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other as noted			

*station-based examination only

Clearance:

☐ Cleared for all participation.

☐ Cleared after completing rehabilitation / examination for: _____

☐ Not cleared for: _____ Reason: _____

Recommendations:

Provider Name: _____ Provider Address: _____

Provider Signature: _____ Date of Examination: _____ / _____ / _____

TAPPS MEDICAL HISTORY FORM

This Medical History Form must be completed annually by the parent (or guardian) and student in order for the student to participate in athletic and selected fine art activities. These questions are designed to assist the practitioner in determining if the student has developed any condition which would make it hazardous to participate in an extracurricular activity.

STUDENT NAME: _____ **GRADE LEVEL:** _____

GENDER: Male / Female **AGE:** _____ **DATE OF BIRTH:** _____/_____/_____

HOME ADDRESS: _____ **CONTACT PHONE #:** (_____) _____-_____

PERSONAL PHYSICIAN: _____ **PHYSICIAN PHONE #:** (_____) _____-_____

If the answer to any question is yes, please discuss the circumstances with your provider at the time of the physical examination.

	YES	NO	UNKNOWN
Have you had a medical illness or injury since your last physical?	☐	☐	☐
Have you been hospitalized overnight in the past year?	☐	☐	☐
Have you ever had surgery?	☐	☐	☐
Have you ever had prior testing ordered by a physician?	☐	☐	☐
Have you ever passed out during or after exercise?	☐	☐	☐
Have you ever had chest pains during or after exercise?	☐	☐	☐
Do you get tired more quickly than your friends during exercise?	☐	☐	☐
Have you ever had your racing of your heart?	☐	☐	☐
Have your ever had your heart skip beats?	☐	☐	☐
Have you been diagnosed with high blood pressure?	☐	☐	☐
Have you been diagnosed with high cholesterol?	☐	☐	☐
Have you ever been diagnosed with a heart murmur?	☐	☐	☐
Has any member of your biological family died of heart problems or sudden unexplained death prior to the age of 50?	☐	☐	☐
Has any biological family member been diagnosed with an enlarged heart (dilated Cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion Channelopathy (Brugada Syndrome, etc), Marfan's Syndrome or abnormal heart rhythm?	☐	☐	☐
Have you had a severe viral infection (such as myocarditis or mononucleosis) within the last month?	☐	☐	☐

TAPPS MEDICAL HISTORY FORM

	YES	NO	UNKNOWN
Has a physician ever denied or restricted your participation in extracurricular activities for any heart related problems?	☐	☐	☐
Have you ever had a diagnosed head injury or concussion?	☐	☐	☐
Have you ever been knocked out, become unconscious or lost memories?	☐	☐	☐
If yes to the question above, how many times? _____			
If yes, when was your last diagnosed concussion? ___/___/_____			
If Yes, how severe were each of the concussions? Discuss with the Provider			
Have you ever had a seizure?	☐	☐	☐
Do you have frequent or severe headaches?	☐	☐	☐
Have you ever had numbness or tingling in your arms, hands legs or feet?	☐	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐	☐
Have you been dizzy during or after exercise?	☐	☐	☐
Have you ever been ill from exercising in the heat?	☐	☐	☐
Have you ever had problems with your eyes or vision?	☐	☐	☐
Have you ever been unexpectedly short of breath while exercising?	☐	☐	☐
Have you been diagnosed by a physician with asthma?	☐	☐	☐
Do you have seasonal allergies which require medical attention or treatment?	☐	☐	☐
Are you missing any paired organs?	☐	☐	☐
Are you presently under a doctor's care for any condition?	☐	☐	☐
Are you currently taking any prescription or nonprescription medication?	☐	☐	☐
Are you presently using an inhaler, prescribed or nonprescribed?	☐	☐	☐
Do you have any known allergies (pollen, medicine, food or insects)?	☐	☐	☐
Do you have current skin problems (examples: itching, rashes, acne, warts, blisters or fungus)?	☐	☐	☐
Do you want to weigh more or less than you do today?	☐	☐	☐
Do you feel stressed out?	☐	☐	☐
Have you ever been diagnosed with or treated by a physician for sickle cell trait or sickle cell disease?	☐	☐	☐

TAPPS MEDICAL HISTORY FORM

	YES	NO	UNKNOWN
Do you use any special protective or corrective equipment that are not usually used for your particular activities (examples: knee brace, neck roll, foot orthotics, retainer, prescription goggles or hearing aid)?	☐	☐	☐
Have you ever had swelling after a sprain, strain or injury?	☐	☐	☐

	YES	NO	UNKNOWN
Have you ever broken or fractured any bones or dislocated any joints?	☐	☐	☐

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, please check each box below that applies.

HEAD	☐	ELBOW	☐	HIP	☐
NECK	☐	FOREARM	☐	THIGH	☐
BACK	☐	WRIST	☐	KNEE	☐
CHEST	☐	HAND	☐	SHIN / CALF	☐
SHOULDER	☐	FINGER	☐	ANKLE	☐
UPPER ARM	☐	FOOT	☐		

Female Students Only (If left blank I agree to provide such information to the provider at the time of examination)

When was your first menstrual period? ___/_____

When was your most recent menstrual period? ___/_____

How much time do you usually have from the start of one period to the start of another? _____ days

What was the longest time between periods in the last year? _____ days

How many periods have you had in the last year?

Male Students Only (If left blank I agree to provide such information to the provider at the time of examination)

Are you missing a testicle? YES NO

Do you have any testicular pain? YES NO

Do you have any testicular swelling or masses? YES NO

TAPPS MEDICAL HISTORY FORM

It is understood that even though protective equipment is worn by the student participant, whenever needed and as prescribed, the possibility of accident or injury still remains. Salem Lutheran School does not assume any responsibility should injury occur.

If in the judgement of any representative of the school the student should need immediate care and / or treatment as a result of any injury or illness, I do hereby request, authorize and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or designated school representative. I do hereby indemnify and save harmless Salem Lutheran School, treating medical establishment and representatives of each from any claim by any on account of such care and treatment of said student.

If, between the date affixed to this document and the beginning of extracurricular training, competition, or performance any injury or illness should occur that may limit the student's participation, I agree to promptly notify the recognized and designated authority at the member school of such injury or illness.

I hereby state that to the best of my knowledge, my answers to the questions asked on this form are complete and correct. I understand that failure to provide truthful and complete responses could subject the student to non-participation at Salem Lutheran School.

Student Full Name: _____

Student Signature: _____

Date of Signature: _____ / _____ / _____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date of Signature: _____ / _____ / _____