



Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

- | | Yes | No | | Yes | No |
|---|-------|-------|--|---------------|-----------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | _____ | _____ | 26. Have you ever become ill from exercising in the heat? | _____ | _____ |
| 2. Do you have an ongoing chronic illness? | _____ | _____ | 27. Do you cough, wheeze or have trouble breathing during or after activity? | _____ | _____ |
| 3. Have you ever been hospitalized overnight? | _____ | _____ | 28. Do you have asthma? | _____ | _____ |
| 4. Have you ever had surgery? | _____ | _____ | 29. Do you have seasonal allergies that require medical treatment? | _____ | _____ |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | _____ | _____ | 30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? | _____ | _____ |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | _____ | _____ | 31. Have you had any problems with your eyes or vision? | _____ | _____ |
| 7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? | _____ | _____ | 32. Do you wear glasses, contacts or protective eyewear? | _____ | _____ |
| 8. Have you ever had a rash or hives develop during or after exercise? | _____ | _____ | 33. Have you ever had a sprain, strain or swelling after injury? | _____ | _____ |
| 9. Have you ever passed out during or after exercise? | _____ | _____ | 34. Have you broken or fractured any bones or dislocated any joints? | _____ | _____ |
| 10. Have you ever been dizzy during or after exercise? | _____ | _____ | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | _____ | _____ |
| 11. Have you ever had chest pain during or after exercise? | _____ | _____ | <i>If yes, check appropriate blank and explain below:</i> | | |
| 12. Do you get tired more quickly than your friends do during exercise? | _____ | _____ | _____ Head | _____ Elbow | _____ Hip |
| 13. Have you ever had racing of your heart or skipped heartbeats? | _____ | _____ | _____ Neck | _____ Forearm | _____ Thigh |
| 14. Have you had high blood pressure or high cholesterol? | _____ | _____ | _____ Back | _____ Wrist | _____ Knee |
| 15. Have you ever been told you have a heart murmur? | _____ | _____ | _____ Chest | _____ Hand | _____ Shin/Calf |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | _____ | _____ | _____ Shoulder | _____ Finger | _____ Ankle |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | _____ | _____ | _____ Upper Arm | _____ Foot | |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | _____ | _____ | 36. Do you want to weigh more or less than you do now? | _____ | _____ |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? | _____ | _____ | 37. Do you lose weight regularly to meet weight requirements for your sport? | _____ | _____ |
| 20. Have you ever had a head injury or concussion? | _____ | _____ | 38. Do you feel stressed out? | _____ | _____ |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | _____ | _____ | 39. Have you ever been diagnosed with sickle cell anemia? | _____ | _____ |
| 22. Have you ever had a seizure? | _____ | _____ | 40. Have you ever been diagnosed with having the sickle cell trait? | _____ | _____ |
| 23. Do you have frequent or severe headaches? | _____ | _____ | 41. Record the dates of your most recent immunizations (shots) for: | | |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet? | _____ | _____ | Tetanus: _____ Measles: _____ | | |
| 25. Have you ever had a stinger, burner or pinched nerve? | _____ | _____ | Hepatitis B: _____ Chickenpox: _____ | | |

FEMALES ONLY (optional)

42. When was your first menstrual period? _____
 43. When was your most recent menstrual period? _____
 44. How much time do you usually have from the start of one period to the start of another? _____
 45. How many periods have you had in the last year? _____
 46. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: _____ Date: ____/____/____ Signature of Parent/Guardian: _____ Date: ____/____/____



Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

Part 3, Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____, ____/____)

Temperature: _____ Hearing: right: P _____ F _____ left: P _____ F _____

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS NORMAL ABNORMAL FINDINGS INITIALS*

MEDICAL

- | | | | |
|---------------------------|-------|-------|-------|
| 1. Appearance | _____ | _____ | _____ |
| 2. Eyes/Ears/Nose/Throat | _____ | _____ | _____ |
| 3. Lymph Nodes | _____ | _____ | _____ |
| 4. Heart | _____ | _____ | _____ |
| 5. Pulses | _____ | _____ | _____ |
| 6. Lungs | _____ | _____ | _____ |
| 7. Abdomen | _____ | _____ | _____ |
| 8. Genitalia (males only) | _____ | _____ | _____ |
| 9. Skin | _____ | _____ | _____ |

MUSCULOSKELETAL

- | | | | |
|-------------------|-------|-------|-------|
| 10. Neck | _____ | _____ | _____ |
| 11. Back | _____ | _____ | _____ |
| 12. Shoulder/Arm | _____ | _____ | _____ |
| 13. Elbow/Forearm | _____ | _____ | _____ |
| 14. Wrist/Hand | _____ | _____ | _____ |
| 15. Hip/Thigh | _____ | _____ | _____ |
| 16. Knee | _____ | _____ | _____ |
| 17. Leg/Ankle | _____ | _____ | _____ |
| 18. Foot | _____ | _____ | _____ |

* - station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

____ Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____