

INSTRUCTIONS: 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: ____/____/____
 Social Security #: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone Number:(____) _____ Work Phone Number:(____) _____
 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? | ___ | ___ | 27. Do you cough, wheeze, or have trouble breathing during or after activity? | ___ | ___ |
| 2. Do you have an ongoing chronic illness? | ___ | ___ | 28. Do you have asthma? | ___ | ___ |
| 3. Have you ever been hospitalized overnight? | ___ | ___ | 29. Do you have seasonal allergies that require medical treatment? | ___ | ___ |
| 4. Have you ever had surgery? | ___ | ___ | 30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | ___ | ___ |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 31. Have you had any problems with your eyes or vision? | ___ | ___ |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ___ | ___ | 32. Do you wear glasses, contacts, or protective eyewear? | ___ | ___ |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ___ | ___ | 33. Have you ever had a sprain, strain, or swelling after injury? | ___ | ___ |
| 8. Have you ever had a rash or hives develop during or after exercise? | ___ | ___ | 34. Have you broken or fractured any bones or dislocated any joints? | ___ | ___ |
| 9. Have you ever passed out during or after exercise? | ___ | ___ | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ___ | ___ |
| 10. Have you ever been dizzy during or after exercise? | ___ | ___ | <i>If yes, check appropriate blank and explain below.</i> | | |
| 11. Have you ever had chest pain during or after exercise? | ___ | ___ | ___ Head | ___ Elbow | ___ Hip |
| 12. Do you get tired more quickly than your friends do during exercise? | ___ | ___ | ___ Neck | ___ Forearm | ___ Thigh |
| 13. Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ | ___ Back | ___ Wrist | ___ Knee |
| 14. Have you had high blood pressure or high cholesterol? | ___ | ___ | ___ Chest | ___ Hand | ___ Shin/Calf |
| 15. Have you ever been told you have a heart murmur? | ___ | ___ | ___ Shoulder | ___ Finger | ___ Ankle |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | ___ | ___ | ___ Upper Arm | ___ Foot | |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ___ | ___ | 36. Do you want to weigh more or less than you do now? | ___ | ___ |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ | 37. Do you lose weight regularly to meet weight requirements for your sport? | ___ | ___ |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ___ | ___ | 38. Do you feel stressed out? | ___ | ___ |
| 20. Have you ever had a head injury or concussion? | ___ | ___ | 39. Record the dates of your most recent immunizations (shots) for: | | |
| 21. Have you ever been knocked out, become unconscious, or lost your memory? | ___ | ___ | Tetanus: _____ | Measles: _____ | |
| 22. Have you ever had a seizure? | ___ | ___ | Hepatitis B: _____ | Chickenpox: _____ | |
| 23. Do you have frequent or severe headaches? | ___ | ___ | 40. Have you ever been diagnosed with sickle cell anemia? | ___ | ___ |
| 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | ___ | ___ | 41. Have you ever been diagnosed with having the sickle cell trait? | ___ | ___ |
| 25. Have you ever had a stinger, burner, or pinched nerve? | ___ | ___ | FEMALES ONLY (optional) | | |
| 26. Have you ever become ill from exercising in the heat? | ___ | ___ | 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 FHSAA 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: _____

**THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
PRE-PARTICIPATION PHYSICAL EVALUATION**

20____-20____

ECHO Needed:

Yes No

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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*
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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/Ann | _____ | _____ | _____ |
| 13. Elbow/Forearm | _____ | _____ | _____ |
| 14. Wrist/Hand | _____ | _____ | _____ |
| 15. Hip/Thigh | _____ | _____ | _____ |
| 16. Knee | _____ | _____ | _____ |
| 17. Leg/Ankle | _____ | _____ | _____ |
| 18. Foot | _____ | _____ | _____ |

ECHOCARDIOGRAM (Optional) _____

* - station-based examination only Year student-athlete received Echo: _____

ASSESSMENT OF EXAMINING PHYSICIAN

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 or type): _____ Date: _____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____, MD or DO

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were 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: _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD or DO

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.