



# Preparticipation Physical Evaluation (Page 1 of 3)

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## 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 Thigh
13. Have you ever had racing of your heart or skipped heartbeats?	____	____	____ Neck	____ Forearm	____ Knee
14. Have you had high blood pressure or high cholesterol?	____	____	____ Back	____ Wrist	____ Shin/Calf
15. Have you ever been told you have a heart murmur?	____	____	____ Chest	____ Hand	____ Ankle
16. Has any family member or relative died of heart problems or sudden death before age 50?	____	____	____ Shoulder	____ Finger	____
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 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: \_\_\_\_/\_\_\_\_/\_\_\_\_



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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 \_\_\_\_\_
- 10. Neurological \_\_\_\_\_
- 11. Psychiatric \_\_\_\_\_

**MUSCULOSKELETAL**

- 12. Neck \_\_\_\_\_
- 13. Back \_\_\_\_\_
- 14. Shoulder/Arm \_\_\_\_\_
- 15. Elbow/Forearm \_\_\_\_\_
- 16. Wrist/Hand \_\_\_\_\_
- 17. Hip/Thigh \_\_\_\_\_
- 18. Knee \_\_\_\_\_
- 19. Leg/Ankle \_\_\_\_\_
- 20. 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: \_\_\_\_\_



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Student's Name: \_\_\_\_\_

**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): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Signature of Physician: \_\_\_\_\_

*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.*