EL2

Florida High School Athletic Association

# Preparticipation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school.

## 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: ______________________

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 |
|---|---|---|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | ___ | ___ |
| 2. Do you have an ongoing chronic illness? | ___ | ___ |
| 3. Have you ever been hospitalized overnight? | ___ | ___ |
| 4. Have you ever had surgery? | ___ | ___ |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ___ | ___ |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ___ | ___ |
| 8. Have you ever had a rash or hives develop during or after exercise? | ___ | ___ |
| 9. Have you ever passed out during or after exercise? | ___ | ___ |
| 10. Have you ever been dizzy during or after exercise? | ___ | ___ |
| 11. Have you ever had chest pain during or after exercise? | ___ | ___ |
| 12. Do you get tired more quickly than your friends do during exercise? | ___ | ___ |
| 13. Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ |
| 14. Have you had high blood pressure or high cholesterol? | ___ | ___ |
| 15. Have you ever been told you have a heart murmur? | ___ | ___ |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | ___ | ___ |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ___ | ___ |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ___ | ___ |
| 20. Have you ever had a head injury or concussion? | ___ | ___ |
| 21. Have you ever been knocked out, become unconscious, or lost your memory? | ___ | ___ |
| 22. Have you ever had a seizure? | ___ | ___ |
| 23. Do you have frequent or severe headaches? | ___ | ___ |
| 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | ___ | ___ |
| 25. Have you ever had a stinger, burner, or pinched nerve? | ___ | ___ |
| 26. Have you ever become ill from exercising in the heat? | ___ | ___ |
| 27. Do you cough, wheeze, or have trouble breathing during or after activity? | ___ | ___ |
| 28. Do you have asthma? | ___ | ___ |
| 29. Do you have seasonal allergies that require medical treatment? | ___ | ___ |
| 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)? | ___ | ___ |
| 31. Have you had any problems with your eyes or vision? | ___ | ___ |
| 32. Do you wear glasses, contacts, or protective eyewear? | ___ | ___ |
| 33. Have you ever had a sprain, strain, or swelling after injury? | ___ | ___ |
| 34. Have you broken or fractured any bones or dislocated any joints? | ___ | ___ |
| 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ___ | ___ |

*If yes, check appropriate blank and explain below.*

| | | |
|---|---|---|
| ___ Head | ___ Elbow | ___ Hip |
| ___ Neck | ___ Forearm | ___ Thigh |
| ___ Back | ___ Wrist | ___ Knee |
| ___ Chest | ___ Hand | ___ Shin/Calf |
| ___ Shoulder | ___ Finger | ___ Ankle |
| ___ Upper Arm | ___ Foot | |

| | Yes | No |
|---|---|---|
| 36. Do you want to weigh more or less than you do now? | ___ | ___ |
| 37. Do you lose weight regularly to meet weight requirements for your sport? | ___ | ___ |
| 38. Do you feel stressed out? | ___ | ___ |

39. Record the dates of your most recent immunizations (shots) for:

Tetanus: ____________ Measles: ____________

Hepatitus B: ____________ Chickenpox: ____________

**FEMALES ONLY (optional)**

40. When was your first menstrual period? ____________

41. When was your most recent menstrual period? ____________

42. How much time do you usually have from the start of one period to the start of another? ____________

43. How many periods have you had in the last year? ____________

44. 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 11.8, 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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# Preparticipation Physical Evaluation (Page 2 of 2)

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## Part 3. Physical Examination (to be completed by physician).

Student's Name: ______________________________ Date of Birth: ____ ____ ____

Height: __________ Weight: __________ % Body Fat (optional): __________ Pulse: __________ Blood Pressure: ___/___ (___/___, ___/___)

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

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.

____ Not cleared for: ______________________ Reason: ______________________

____ Cleared after completing evaluation/rehabilitation for: ______________________

____ Referred to ______________________ For: ______________________

Recommendations: ______________________

Name of Physician (print or type): ______________________ Date: __________

Address: ______________________

Signature of Physician: ______________________, 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.

____ 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.*