EL2

Revised 03/16

Florida High School Athletic Association

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
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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
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 non-prescription (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, pollen, latex, 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, blisters or pressure sores)?	____	____
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 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)?	____	____
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		
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	Have you ever been diagnosed with sickle cell anemia?	____	____
40	Have you ever been diagnosed with having the sickle cell trait?	____	____
41	Record the dates of your most recent immunizations (shots) for		
	Tetanus _____ Measles: _____		
	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*
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: _____

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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