



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 Phone: (____) _____
 Home Address: _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____ Home Phone Number: (____) _____ Work Phone Number: (____) _____
 Relationship to Student: _____ City/State: _____ Office Phone: (____) _____
 Personal/Family Physician: _____

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

1. Have you had a medical illness or injury since your last check up or sports physical?	Yes	No	26. Have you ever become ill from exercising in the heat?	Yes	No
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 or 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 nonprescription (over-the-counter) medications or pills or using an inhaler?	_____	_____	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, reamer on your teeth, 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, to pollen, 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 strain, sprain, 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 ever 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?	_____	_____			
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	Tetanus _____	Meesles _____	
20. Have you ever had a head injury or concussion?	_____	_____	Hepatitis B _____	Chickendpox _____	
21. Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	FEMALES ONLY (optional)		
22. Have you ever had a seizure?	_____	_____	40. When was your first menstrual period? _____		
23. Do you have frequent or severe headaches?	_____	_____	41. When was your most recent menstrual period? _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_____	_____	42. How much time do you usually have from the start of one period to the start of another? _____		
25. Have you ever had a stinger, burner, or pinched nerve?	_____	_____	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 FHSSA-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: _____



**Florida High School Athletic Association
Preparticipation Physical Evaluation (Page 2 of 2)**

Revised 4/06

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 below.

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

Date of Birth: ____/____/____

Student's Name: _____ Height: _____ Weight: _____ %BodyFat(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/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. Reason: _____

Cleared after completing evaluation/rehabilitation for: _____ For: _____

Recommendations: _____

Name of Physician/Nurse Practitioner (print or type): _____ Date: _____

Address: _____

Signature of Physician/Nurse Practitioner: _____

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. Reason: _____

Not cleared for: _____ Reason: _____

Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print or type): _____ 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.