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. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

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: _____		
Hepatitus 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.