EL2

Florida High School Athletic Association

Revised 03/10

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.

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.

	Question	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	

	Question	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.	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: ______________________