



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.

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, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Foot, Hip, Thigh, Knee, Shin/Calf, Ankle. 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, Chickpox. 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:





Preparticipation Physical Evaluation (Page 2 of 3)

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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: \_\_\_\_\_

PHYSICIANS STAMP REQUIRED

12



# Preparticipation Physical Evaluation (Page 3 of 3)

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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.*

PHYSICIANS  
STAMP  
REQUIRED

13