



Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school.

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: \_\_\_\_\_
Person to Contact in Case of Emergency: \_\_\_\_\_
Relationship to Student: \_\_\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_
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? Yes No
2. Do you have an ongoing chronic illness? Yes No
3. Have you ever been hospitalized overnight? Yes No
4. Have you ever had surgery? Yes No
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Yes No
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes No
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Yes No
8. Have you ever had a rash or hives develop during or after exercise? Yes No
9. Have you ever passed out during or after exercise? Yes No
10. Have you ever been dizzy during or after exercise? Yes No
11. Have you ever had chest pain during or after exercise? Yes No
12. Do you get tired more quickly than your friends do during exercise? Yes No
13. Have you ever had racing of your heart or skipped heartbeats? Yes No
14. Have you had high blood pressure or high cholesterol? Yes No
15. Have you ever been told you have a heart murmur? Yes No
16. Has any family member or relative died of heart problems or sudden death before age 50? Yes No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes No
18. Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Yes No
20. Have you ever had a head injury or concussion? Yes No
21. Have you ever been knocked out, become unconscious, or lost your memory? Yes No
22. Have you ever had a seizure? Yes No
23. Do you have frequent or severe headaches? Yes No
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No
25. Have you ever had a stinger, burner, or pinched nerve? Yes No
26. Have you ever become ill from exercising in the heat? Yes No
27. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No
28. Do you have asthma? Yes No
29. Do you have seasonal allergies that require medical treatment? Yes No
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, retainer on your teeth, hearing aid)? Yes No
31. Have you had any problems with your eyes or vision? Yes No
32. Do you wear glasses, contacts, or protective eyewear? Yes No
33. Have you ever had a sprain, strain, or swelling after injury? Yes No
34. Have you broken or fractured any bones or dislocated any joints? Yes No
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No
If yes, check appropriate blank and explain below.
Head Neck Elbow Forearm Hip
Wrist Hand Thigh
Chest Hand Shin/Calf
Shoulder Finger Ankle
Upper Arm Foot
36. Do you want to weigh more or less than you do now? Yes No
37. Do you lose weight regularly to meet weight requirements for your sport? Yes No
38. Do you feel stressed out? Yes No
39. Record the dates of your most recent immunizations (shots) for:
Tetanus: \_\_\_\_\_ Measles: \_\_\_\_\_
Hepatitis B: \_\_\_\_\_ Chickenpox: \_\_\_\_\_
FEMALES ONLY (optional)
40. When was your first menstrual period? \_\_\_\_\_
41. When was your most recent menstrual period? \_\_\_\_\_
42. How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
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 FHSAA 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: \_\_\_\_\_



Preparticipation Physical Evaluation (Page 2 of 2)

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

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ %Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_/\_\_\_ (\_\_\_/\_\_\_, \_\_\_/\_\_\_)
Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Table with 4 columns: FINDINGS, NORMAL, ABNORMAL FINDINGS, INITIALS\*. Rows include MEDICAL (Appearance, Eyes/Ears/Nose/Throat, Lymph Nodes, Heart, Pulses, Lungs, Abdomen, Genitalia, Skin) and MUSCULOSKELETAL (Neck, Back, Shoulder/Arm, Elbow/Forearm, Wrist/Hand, Hip/Thigh, Knee, Leg/Ankle, 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.
Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
Referred to \_\_\_\_\_ 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.
Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_
Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, MD or DO