



# 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  |  | Yes         | No            |
|---|-----|-----|--|-------------|---------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?                                      | ___ | ___ | 26. Have you ever become ill from exercising in the heat?  | ___         | ___           |
| 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 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 non-prescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 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)? | ___         | ___           |
| 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, pollen, latex, 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 sprain, strain 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 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?                            | ___ | ___ | 36. Do you want to weigh more or less than you do now?   | ___         | ___           |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?    | ___ | ___ | 37. Do you lose weight regularly to meet weight requirements for your sport?   | ___         | ___           |
| 20. Have you ever had a head injury or concussion?  | ___ | ___ | 38. Do you feel stressed out?  | ___         | ___           |
| 21. Have you ever been knocked out, become unconscious or lost your memory?   | ___ | ___ | 39. Have you ever been diagnosed with sickle cell anemia?  | ___         | ___           |
| 22. Have you ever had a seizure?  | ___ | ___ | 40. Have you ever been diagnosed with having the sickle cell trait?  | ___         | ___           |
| 23. Do you have frequent or severe headaches?   | ___ | ___ | 41. Record the dates of your most recent immunizations (shots):  |             |               |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet?   | ___ | ___ | Tetanus: _____ Measles: _____  |             |               |
| 25. Have you ever had a stinger, burner or pinched nerve?   | ___ | ___ | Hepatitis 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: \_\_\_\_/\_\_\_\_/\_\_\_\_





# Preparticipation Physical Evaluation (Page 3 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.**

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.*

## Cardiology Report: Electrocardiogram (ECG)

In accordance with School Board Policy JJ titled Extracurricular Activities, as part of the high school athletic packets, The School Board of Orange County, Florida is requiring each student athlete wishing to participate in high school athletics to have an electrocardiogram (ECG) screening prior to participating in his/her first athletic sport in high school.

Date: \_\_\_\_\_ Student's Name: (Print) \_\_\_\_\_

Name of School: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID #: \_\_\_\_\_

An ECG Screening was completed and evaluated by an outside vendor. Attached is the documentation clearing my child for participation in high school athletics.

The following represents the findings of the licensed physician or practitioner after reviewing the ECG screening results for my child:

|   |  |                 |
|---|--|-----------------|
| <b><u>Cardiac Clearance:</u></b><br><b>(To be completed by a Cardiologist or Pediatric Cardiologist*)</b> |  |                 |
| Low Risk/Cleared for Participation: _____   | Higher Risk/Not Cleared for Participation: _____ | Date: _____     |
| Cardiologist or Pediatric Cardiologist*:<br><br>_____   |  |                 |
| (Print Name)  | (Signature)                                      |                 |
| Name of Office: _____   | Phone: _____                                     |                 |
| Address: _____  | City: _____                                      | Zip Code: _____ |

\_\_\_\_\_  
Parent/Legal Guardian Name Printed

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Legal Guardian Phone #

*\*See Section 1006.20(2)(c), Florida Statutes.*