



Preparticipation Physical Evaluation (Page 1 of 2)

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: \_\_\_\_\_
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.

Table with 4 columns: Question, Yes, No, Yes, No. Contains 34 numbered questions about medical history and physical fitness. Includes a section for 'If yes, check appropriate blank and explain below' with body part checkboxes (Head, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Foot, Hip, Thigh, Knee, Shin/Calf, Ankle). Questions cover topics like medical illness, chronic conditions, hospitalizations, surgery, medications, supplements, allergies, injuries, family history, and skin problems.

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: \_\_\_\_\_



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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 \_\_\_\_\_

| FINDINGS                  | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---------------------------|--------|-------------------|-----------|
| <b>MEDICAL</b>            |        |                   |           |
| 1. Appearance             | _____  | _____             | _____     |
| 2. Eyes/Ears/Nose/Throat  | _____  | _____             | _____     |
| 3. Lymph Nodes            | _____  | _____             | _____     |
| 4. Heart                  | _____  | _____             | _____     |
| 5. Pulses                 | _____  | _____             | _____     |
| 6. Lungs                  | _____  | _____             | _____     |
| 7. Abdomen                | _____  | _____             | _____     |
| 8. Genitalia (males only) | _____  | _____             | _____     |
| 9. Skin                   | _____  | _____             | _____     |
| <b>MUSCULOSKELETAL</b>    |        |                   |           |
| 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/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: \_\_\_\_\_

*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.*