

Signature of Student:

Florida High School Athletic Association

Revised 03/16

Date: __

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.

ident's Name:				Sex:	Age:	Date of Birth:	/
hool:							
me Address:							
me of Parent/Guardian:							
rson to Contact in Case of Emergency:							
lationship to Student:						Cell Phone: ()	
rsonal/Family Physician:							
sonal/Paining Physician.			nty/State.			office I none. () _	
art 2. Medical History (to be comp	oleted by student or	parent). E	Explain "ves" an	swers below.	Circle que	estions vou don't kno	w answ
	Yes				•	J	Yes
Have you had a medical illness or injury sind	ce your last		Have you ever b				
check up or sports physical?		27.		vheeze or have	trouble brea	athing during or after	
Do you have an ongoing chronic illness?		20	activity?	1 0			
Have you ever been hospitalized overnight?			Do you have ast		d 4 .	11 14 4 49	
Have you ever had surgery?			•	_		medical treatment?	
Are you currently taking any prescription or prescription (over-the-counter) medications		30.				etive equipment or r your sport or position	
using an inhaler?	or bills or					foot orthotics, shunt,	
Have you ever taken any supplements or vita	amins to		retainer on your			oranomos, simili,	
help you gain or lose weight or improve you		31.	Have you had an		-	or vision?	
performance?			Do you wear gla				
Do you have any allergies (for example, poll	en, latex,		Have you ever h		-		
medicine, food or stinging insects)?		34.	Have you broker	n or fractured a	ny bones or	dislocated any joints?	
Have you ever had a rash or hives develop d	uring or	35.			ms with pair	n or swelling in muscles,	,
after exercise?	vroigo?		tendons, bones o	-	, -		
Have you ever passed out during or after exe Have you ever been dizzy during or after exe			If yes, check app				
Have you ever had chest pain during or after			— Head			_ Hip _ Thick	
Do you get tired more quickly than your frie	nds do		Neck	Forea	n	_ Thigh	
during exercise?	iius uo		Back	— Wrist		_ Knee _ Shin/Calf	
Have you ever had racing of your heart or sk	ripped		Shoulder	Wrist Hand Finge	-r	_ Snin/Call _ Ankle	
heartbeats?			Shoulder Upper Arm			_ AHAIC	
Have you had high blood pressure or high ch		36	Do you want to			u do now?	
Have you ever been told you have a heart me	urmur?	50.		-	-	ht requirements for your	
Has any family member or relative died of h	eart		sport?	J	8.	1	
problems or sudden death before age 50?		38.	Do you feel stres	ssed out?			
Have you had a severe viral infection (for ex		39.	Have you ever b	een diagnosed	with sickle	cell anemia?	
myocarditis or mononucleosis) within the last						the sickle cell trait?	
Has a physician ever denied or restricted you participation in sports for any heart problems						inizations (shots) for:	
Do you have any current skin problems (for			Tetanus:		Measles:		
itching, rashes, acne, warts, fungus, blisters or p	1 /		Hepatitus B:		Chickenpox	::	
Have you ever had a head injury or concussi			MATEGONIST	4! D			
Have you ever been knocked out, become ur	iconscious		MALES ONLY (marria do		
or lost your memory?			When was your			od?	_
Have you ever had a seizure?						od? the start of one period to	_
Do you have frequent or severe headaches?			the start of anoth		nave Holli t	ine start or one period to	,
Have you ever had numbness or tingling in y	our arms,	45			ad in the last	t year?	_
hands, legs or feet? Have you ever had a stinger, burner or pinche	ed nerve?					in the last year?	
					_		
plain "Yes" answers here:							

Signature of Parent/Guardian:





Florida High School Athletic Association

Revised 03/16

Preparticipation Physical Evaluation (Page 2 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: _								Date of Birth: _	//
Height:	Weig	ht:	% Body Fat (op	tional):		Pulse:	Blood Pressure:	/(/	_ ,/
		Hearing: right: P							
							Unequal		
FINDINGS		NORMAL			ABNO	RMAL FIND	INGS		INITIAL
MEDICAL									
1. Appearan									
-	s/Nose/Throa	it							
3. Lymph N	odes								
4. Heart									
5. Pulses									
6. Lungs									
7. Abdomen	1								
8. Genitalia	(males only)								
9. Skin									
MUSCULOSKEL	ETAL								
10. Neck									
11. Back									
12. Shoulder/	'Arm								
13. Elbow/Fo	rearm								
14. Wrist/Har	nd								
15. Hip/Thigl	h								
16. Knee									
17. Leg/Ankl	e								
18. Foot									
* – station-based	examination	only							
ASSESSMENT (DF EXAMIN	NING PHYSICIAN	N/PHYSICIAN A	SSISTAN	T/NURSE	PRACTITION	NER		
I hereby certify th	at each exan	nination listed above	e was performed	by myself o	or an individ	ual under my o	direct supervision with the	e following conclusion	on(s):
Cleared with	out limitatio	n							
Disability: _					Diagn	osis:			
Precautions:									
Not cleared	for:						Reason:		
Cleared after	r completing	evaluation/rehabili	tation for:						
							For:		
Recommendations	z·								
recommendation	·								
Name of Physician	n/Physician	A coictant/Nursa Dro	ctitioner (print):					Data:	





Florida High School Athletic Association

dic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

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 app		
I hereby certify that the examination(s) for which referred was/were per	erformed by myself or an individual under my direct supe	ervision with the following conclusion(s)
Cleared without limitation		
Disability:	Diagnosis:	
Precautions:		
Not cleared for:		
Cleared after completing evaluation/rehabilitation for:		
Recommendations:		
Name of Physician (print):		
Address:		
Signature of Physician:		
Based on recommendations developed by the American Academy of Family Phys	sicians, American Academy of Pediatrics, American Medical Socie	ety for Sports Medicine, American Orthopae-

– 3 –