

EL2
Revised 05/18

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: _____
 Home Address: _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____
 Referral to Student: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Personal ID #: _____ City/State: _____ Office Phone: _____

ANSWER ALL QUESTIONS

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, shoe, 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 had chest pain 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?	___	If yes, check appropriate blank and explain below:		
12. Do you get tired more quickly than your friends do during exercise?	___	___ Neck	___ Elbow	___ Hip/Thigh
13. Have you ever had racing of your heart or skipped heartbeats?	___	___ Back	___ Wrist	___ Shin/Calf
14. Have you had high blood pressure or high cholesterol?	___	___ Chest	___ Hand	___ Ankle
15. Have you ever been told you have a heart murmur?	___	___ Shoulder	___ Finger	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___ Upper Arm	___ Foot	___
17. Have you had a recent viral infection (for example, mononucleosis or mono) within the last month?	___	36. Do you want to weigh more or less than you do now?	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	___	38. Do you feel stressed out?	___	___
20. Have you ever had a head injury or concussion?	___	39. Have you ever been diagnosed with sickle cell anemia?	___	___
21. Have you ever been knocked out, become unconscious or lost your memory?	___	40. Have you ever been diagnosed with having the sickle cell trait?	___	___
22. Have you ever had a seizure?	___	41. Explain "Yes" answers here: _____	___	___
23. Do you have frequent or severe headaches?	___	42. When was your first menstrual period? _____	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	43. When was your most recent menstrual period? _____	___	___
25. Have you ever had a stinger, burner or pinched nerve?	___	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: _____

NEED SIGNATURES!

Signature of Student: _____ Date: _____

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Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physical 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/ _____ Corrected: Yes No Papsils: Equal Unequal

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	___	___	___
2. Eyes/Ears/Nose/Throat	___	___	___
3. Lymph Nodes	___	___	___
4. Heart	___	___	___
5. Poles	___	___	___
6. Lungs	___	___	___
7. Abdomen	___	___	___
8. Genitalia (males only)	___	___	___
9. Skin	___	___	___
10. Neurological	___	___	___
11. Psychiatric	___	___	___
MUSCULOSKELETAL			
12. Neck	___	___	___
13. Back	___	___	___
14. Shoulder/Arm	___	___	___
15. Elbow/Forearm	___	___	___
16. Wrist/Hand	___	___	___
17. Hip/Thigh	___	___	___
18. Knee	___	___	___
19. Leg/Ankle	___	___	___
20. Foot	___	___	___

* - station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that the examination(s) listed above was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

___ Cleared without limitation. Diagnosis: _____
 ___ 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: _____

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Student's Name: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) listed above was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

___ Cleared without limitation. Diagnosis: _____
 ___ Not cleared for: _____ Reason: _____
 ___ Cleared after completing evaluation/rehabilitation for: _____
 ___ Referred to: _____ For: _____

Name of Physician (print): _____ Date: _____
 Address: _____

Signature of Physician: _____

Based on recommendations developed by the American Academy of Pediatrics, American Medical Society for Sports Medicine, American College of Sports Medicine and American Osteopathic Academy for Sports Medicine

- ANSWER ALL QUESTIONS!
- Don't forget shot information!

- Doctor's Name MUST be Printed
- Doctor's Signature & Date
- Doctors Office Address and Phone # (Or Stamp)

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Only Necessary if Recommendations were made on page 2!!!