

FLORIDA Florida High School Athletic Association
Preparticipation Physical Evaluation (Page 1 of 3)
Revised 05/18

EL2

ANSWER ALL QUESTIONS

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: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Personal Physician: _____ City/State: _____

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? (for example, knee, hand, wrist, elbow, shoulder, hip, ankle, etc.)	_____
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 _____
13. Have you ever had racing of your heart or skipped heartbeats?	_____	Neck _____	Hip/Thigh _____
14. Have you had high blood pressure or high cholesterol?	_____	Forearm _____	Knee _____
15. Have you ever been told you have a heart murmur?	_____	Back _____	Wrist _____
16. Has any family member or relative died of heart problems or sudden death before age 50?	_____	Chest _____	Shin/Calf _____
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	Shoulder _____	Hand _____
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	Upper Arm _____	Foot _____
19. Do you have any current skin problems (for example, itching, rashes, sores, warts, fungus, blisters or pressure sores)?	_____	Lower Arm _____	_____
20. Have you ever had a head injury or concussion?	_____	_____	_____
21. Have you ever been knocked out, become unconscious or lost your memory?	_____	_____	_____
22. Have you ever had a seizure?	_____	_____	_____
23. Do you have frequent or severe headaches?	_____	_____	_____
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____	_____
25. Have you ever had a sting, burner or pinched nerve?	_____	_____	_____

Explain "Yes" answers below: _____

YES ANSWERS MUST BE EXPLAINED HERE

NEED SIGNATURES!

Signature of Student: _____ Date: _____

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Part 3. Personal Information MUST be completed!!!

Student's Name: _____ Weight: _____ Height: _____ Blood Pressure: _____
 Sex: _____ Hearing: right P _____ Left 20 _____ Corrected: Yes No Purple Equal Unusual _____
 Vision: _____
 FINISHERS' LIST: _____ INITIALS: _____

MUST be completed by doctor!

1. Appearance _____
 2. Eyes/Ears/Nose/Throat _____
 3. Lymph Nodes _____
 4. Heart _____
 5. Pulse _____
 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 _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____ Date: _____

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ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for _____ 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: _____

Signature of Physician: _____ Date: _____

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

- ANSWER ALL QUESTIONS!
- COMPLETE PERSONAL INFO
- Don't forget shot information!
- Yes answers MUST be explained at the bottom.

- Student's Information MUST be completed at the TOP!
- Doctor's Name MUST be Printed
- Doctor's Signature & Date
- Doctors Office Address and Phone # (Or Stamp)

Only Necessary if Recommendations were made on page 2 and form MUST be completed by specialist listed on recommendation/precaution etc...