THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Department of Risk Management
75 N. Pace Blvd., Pensacola, FL 32502

PRE-PARTICIPATION PHYSICAL EVALUATION

School: _____ School Year: 20_____-20_____

INSTRUCTIONS: 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: _____/_____/_____

Social Security #: _____ 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.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___
2. Do you have an ongoing chronic illness?	___	___
3. Have you ever been hospitalized overnight?	___	___
4. Have you ever had surgery?	___	___
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___
9. Have you ever passed out during or after exercise?	___	___
10. Have you ever been dizzy during or after exercise?	___	___
11. Have you ever had chest pain during or after exercise?	___	___
12. Do you get tired more quickly than your friends do during exercise?	___	___
13. Have you ever had racing of your heart or skipped heartbeats?	___	___
14. Have you had high blood pressure or high cholesterol?	___	___
15. Have you ever been told you have a heart murmur?	___	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___
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 stinger, burner, or pinched nerve?	___	___
26. Have you ever become ill from exercising in the heat?	___	___

	Yes	No
27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
28. Do you have asthma?	___	___
29. Do you have seasonal allergies that require medical treatment?	___	___
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
31. Have you had any problems with your eyes or vision?	___	___
32. Do you wear glasses, contacts, or protective eyewear?	___	___
33. Have you ever had a sprain, strain, or swelling after injury?	___	___
34. Have you broken or fractured any bones or dislocated any joints?	___	___
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___

If yes, check appropriate blank and explain below.

___ Head	___ Elbow	___ Hip
___ Neck	___ Forearm	___ Thigh
___ Back	___ Wrist	___ Knee
___ Chest	___ Hand	___ Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

36. Do you want to weigh more or less than you do now?	___	___
37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
38. Do you feel stressed out?	___	___

39. Record the dates of your most recent immunizations (shots) for:

Tetanus: _____ Measles: _____

Hepatitus B: _____ Chickenpox: _____

40. Have you ever been diagnosed with sickle cell anemia?	___	___
41. Have you ever been diagnosed with having the sickle cell trait?	___	___

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: _____

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
PRE-PARTICIPATION PHYSICAL EVALUATION **20_____-20_____**

ECHO Needed: ☐ Yes ☐ No

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Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician 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/_____ Left 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal _____

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

* - station-based examination only Year student-athlete received Echo: _____

ASSESSMENT OF EXAMINING PHYSICIAN

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.

____ Disability:_____ Diagnosis:_____

____ Precautions:_____

____ Not cleared for:_____ Reason:_____

____ Cleared after completing evaluation/rehabilitation for:_____

____ Referred to:_____ For:_____

Recommendations:_____

Name of Physician/Physician Assistant/Nurse Practitioner (print or type):_____ Date:_____

Address:_____

Signature of Physician/Physician Assistant/Nurse Practitioner:_____, MD or DO

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 or type):_____ Date:_____

Address:_____

Signature of Physician:_____, MD or DO

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.