

# MIDDLE SCHOOL 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		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
2. Do you have an ongoing chronic illness?	___	___	28. Do you have asthma?	___	___
3. Have you ever been hospitalized overnight?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___
4. Have you ever had surgery?	___	___	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)?	___	___
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___	31. Have you had any problems with your eyes or vision?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___	33. Have you ever had a sprain, strain, or swelling after injury?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___
9. Have you ever passed out during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
10. Have you ever been dizzy during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below.</i>		
11. Have you ever had chest pain during or after exercise?	___	___	___ Head	___ Elbow	___ Hip
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Neck	___ Forearm	___ Thigh
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Back	___ Wrist	___ Knee
14. Have you had high blood pressure or high cholesterol?	___	___	___ Chest	___ Hand	___ Shin/Calf
15. Have you ever been told you have a heart murmur?	___	___	___ Shoulder	___ Finger	___ Ankle
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 severe viral infection (for example, myocarditis or mononucleosis) 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, or blisters)?	___	___	38. Do you feel stressed out?	___	___
20. Have you ever had a head injury or concussion?	___	___	39. Record the dates of your most recent immunizations (shots) for:		
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___	Tetanus: _____	Measles: _____	
22. Have you ever had a seizure?	___	___	Hepatitis B: _____	Chickenpox: _____	
23. Do you have frequent or severe headaches?	___	___	40. Have you ever been diagnosed with sickle cell anemia?	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	41. Have you ever been diagnosed with having the sickle cell trait?	___	___
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	FEMALES ONLY (optional)		
26. Have you ever become ill from exercising in the heat?	___	___	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

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 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 \_\_\_\_\_
- 3. Lymph Nodes \_\_\_\_\_
- 4. Heart \_\_\_\_\_
- 5. Pulses \_\_\_\_\_
- 6. Lungs \_\_\_\_\_
- 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.*

This form must be kept on file at the school.

**Part 1. Student Acknowledgement and Release (to be signed by student)**

If accepted as a representative, I agree to follow the rules of my school and to abide by their decisions. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, including the potential for a concussion, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I release and hold harmless my school, the schools against which it competes, the contest officials, The Beulah Academy of Science, Inc. and The Escambia County School District, of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against The Beulah Academy of Science, Inc and/or The Escambia County School District, because of any accident or mishap involving my athletic participation. I further hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I understand that this authorization is voluntary and that I may revoke it at any time by submitting the revocation in writing to my school. Furthermore, I grant the released parties the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising and promotional materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.**

Date \_\_\_\_\_

Signature of Student \_\_\_\_\_

Name of Student \_\_\_\_\_

**Part 2. Parental/Guardian Consent, Acknowledgement and Release**

**(to be completed, signed by ALL parents/guardians (where divorced or separated, parent/guardian with legal custody must sign), and notarized).**

A. I/we hereby give consent for my child/ward to participate in the following interscholastic sports that I have circled:

Basketball      Swimming & Diving      Track & Field      Cheerleading/Dance      Other: \_\_\_\_\_

B. I/we understand that participation may necessitate an early dismissal from classes.

C. I/we know of, and acknowledge that my child/ward knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I/we release and hold harmless my child's/ward's school, the schools against which it competes, the contest officials and The Beulah Academy of Science Inc. and The Escambia County School District of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against The Beulah Academy of Science, Inc because of any accident or mishap involving the athletic participation of my child/ward. I/we further authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school. I/we agree to assume full financial responsibility for and agree to pay all expenses of such care. I/we understand that it is my responsibility to secure adequate insurance for such first aid and medical care. Furthermore, I/we hereby grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising and promotional materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

D. I/we hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I/we understand that this authorization is voluntary and that I/we may revoke it at any time by submitting the revocation in writing to my child's/ward's school.

E. Please check the appropriate box(es):

\_\_\_\_ My child/ward is covered under my family health insurance plan which has limits of not less than \$25,000.  
(Please attach a photo copy of proof of insurance.)

Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.**

\_\_\_\_\_  
Name of Parent/Guardian (printed)      Signature of Parent/Guardian      Date

\_\_\_\_\_  
Name of Parent/Guardian (printed)      Signature of Parent/Guardian      Date

State of Florida / County of Escambia

Before me personally appeared \_\_\_\_\_ to me well known and known to be the person(s) described in and who executed the forgoing instrument and acknowledged to and before me that \_\_\_\_\_ executed said instrument for the purposes therein expressed.

WITNESS my hand and official seal, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 20 \_\_\_\_\_

My commission expires \_\_\_\_\_

\_\_\_\_\_  
Notary Public, State of Florida

**No student will be allowed to practice or play in any organized sports activity until this document is signed, notarized and returned to the Athletic Department of Beulah Academy of Science, Inc.**



THE SCHOOL DISTRICT OF ESCAMBIA COUNTY  
Department of Curriculum and Instruction  
75 N. Pace Blvd.  
Pensacola, FL 32505

## ANNUAL CONSENT TO STUDENT DRUG SCREENING

SCHOOL YEAR \_\_\_\_\_ - \_\_\_\_\_

I understand that submission to testing for the presence of drugs is a conditions of parking on campus and/or participation in interscholastic athletics and/or extra/co-curricular activities. I further understand if I refuse to take the test, or if the test establishes a violation of the random drug test policy, I will forfeit my privilege of parking on campus and be removed from participation in athletics and/or extra/co-curricular activities until satisfactorily complying with the Random Drug Testing Policy.

By signing and dating this form, I consent to random drug screening and the sanctions thereof throughout the school year. The selection for the random screenings will be performed on a weekly basis with the selected students being notified on the day they are to report for urinalysis.

By signing and dating this form, I understand that the cost of the initial random screening will be paid for by the school district. Furthermore, I understand that the cost of all follow-up drug testing will be the responsibility of the student if the follow-up test results in a positive outcome. If the results are determined to be negative, the district will be responsible for reimbursement. I also understand that the cost for the assessment and rehabilitation program and any additional testing in the event of a violation of the random drug testing policy is also the responsibility of the student.

I hereby consent to the administration of the drug screening and to the conditions listed in this consent. By signing and dating this form, I attest that I have read and understand the attached Random Drug Testing Policy.

Student's Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

Date : \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Date : \_\_\_\_\_ Signature: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Commission Expires: \_\_\_\_\_

(Notary Seal)

If your child is selected for random drug screening, an attempt will be made to notify you either by phone or letter of both selection for screening and the subsequent result. The best number to reach you is \_\_\_\_\_. An alternate number is \_\_\_\_\_.