



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.
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Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 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?	_____	_____	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, shunt, 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 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	_____ Hip
13. Have you ever had racing of your heart or skipped heartbeats?	_____	_____	_____ Neck	_____ Forearm	_____ Thigh
14. Have you had high blood pressure or high cholesterol?	_____	_____	_____ Back	_____ Wrist	_____ Knee
15. Have you ever been told you have a heart murmur?	_____	_____	_____ Chest	_____ Hand	_____ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____	_____ Shoulder	_____ Finger	_____ Ankle
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	_____ Upper Arm	_____ Foot	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____	36. Do you want to weigh more or less than you do now?	_____	_____
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	_____	_____	37. Do you lose weight regularly to meet weight requirements for your sport?	_____	_____
20. Have you ever had a head injury or concussion?	_____	_____	38. Do you feel stressed out?	_____	_____
21. Have you ever been knocked out, become unconscious or lost your memory?	_____	_____	39. Have you ever been diagnosed with sickle cell anemia?	_____	_____
22. Have you ever had a seizure?	_____	_____	40. Have you ever been diagnosed with having the sickle cell trait?	_____	_____
23. Do you have frequent or severe headaches?	_____	_____	41. Record the dates of your most recent immunizations (shots) for:		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____	Tetanus: _____ Measles: _____		
25. Have you ever had a stinger, burner or pinched nerve?	_____	_____	Hepatitis B: _____ Chickenpox: _____		

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: ____/____/____



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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*
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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/Arm | _____ | _____ | _____ |
| 13. Elbow/Forearm | _____ | _____ | _____ |
| 14. Wrist/Hand | _____ | _____ | _____ |
| 15. Hip/Thigh | _____ | _____ | _____ |
| 16. Knee | _____ | _____ | _____ |
| 17. Leg/Ankle | _____ | _____ | _____ |
| 18. Foot | _____ | _____ | _____ |

* – station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

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): _____ 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) 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): _____ Date: ____/____/____

Address: _____

Signature of Physician: _____

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.

OCPS Cardiology Report: Electrocardiogram (ECG) Clearance

Parents/Guardians: An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. In accordance with School Board Policy JJ titled Extracurricular Activities, The School Board of Orange County, Florida is requiring each student athlete wishing to participate in high school athletics to have 1 electrocardiogram (ECG) screening prior to participating in his/her first athletic sport in high school. **The initial ECG may be completed by any licensed physician, including a primary care physician, pediatrician, licensed physician assistant, or certified advanced registered nurse practitioner. If the ECG comes back ABNORMAL, the student may only participate after being cleared by a cardiologist or a pediatric cardiologist.**

Student's Name: (Print): _____ Student ID #: _____ DOB: _____

Parent/Legal Guardian Name Printed

Parent/Legal Guardian Signature

Date



If your ECG was completed by Who We Play For, Orlando Health, Advent Health, or Nemours, you can **STOP** here. Submit the email you received from the organization to Athletic Clearance, along with the top portion of this form completed. Both the email and this form with the top completed must be submitted.

ECG's performed by a PCP, Urgent Care Center, or Walk-in Clinic must complete the form below

PHYSICIAN INSTRUCTIONS: This form is to be completed by an appropriate health care provider (AHCP) trained in the latest ECG interpretation guidelines. It is recommended to interpret ECG readings based on the International Criteria (<https://uwsportscardiology.org/>). After completing and interpreting the ECG, select the appropriate box below. If the ECG is interpreted as NORMAL, complete the Normal Electrocardiogram Clearance. If the initial ECG is interpreted as ABNORMAL, the student must be referred to a cardiologist. Only a cardiologist can clear a student with an ABNORMAL ECG interpretation.

NORMAL Electrocardiogram Clearance:

(To be completed in full by a licensed physician, PA or ARNP)

I hereby certify that an ECG was performed by myself or an individual under my direct supervision with the following conclusion:

☐ Low Risk/Cleared for Participation

Name of Physician/PA/ARNP (print)

Signature of Physician/PA/ARNP

Date

Stamp of Physician Office: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____



An ABNORMAL ECG was found and student has been referred to cardiology. Physician name: _____ Date: _____

ABNORMAL Electrocardiogram Clearance:

(To be completed in full by a cardiologist or pediatric cardiologist)

An abnormal ECG screening was found and the student was subsequently evaluated by a cardiologist or pediatric cardiologist.

☐ I hereby certify that the student above has had a cardiac evaluation and is cleared for athletic participation from a cardiac perspective.

Name of Cardiologist/Pediatric Cardiologist (print)

Signature of Cardiologist/Pediatric Cardiologist

Date

Stamp of Cardiology Office: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____