



Florida High School Athletic Association

## Preparticipation Physical Evaluation (Page 1 of 2)

Revised 3/08

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: \_\_\_\_\_  
 School: \_\_\_\_\_ 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?	_____	_____	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 nonprescription (over-the-counter) medications or pills or using an inhaler?	_____	_____	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)?	_____	_____
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, to pollen, 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, or blisters)?	_____	_____	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. Record the dates of your most recent immunizations (shots) for:		
22. Have you ever had a seizure?	_____	_____	Tetanus: _____ Measles: _____		
23. Do you have frequent or severe headaches?	_____	_____	Hepatitis B: _____ Chickenpox: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_____	_____	<b>FEMALES ONLY (optional)</b>		
25. Have you ever had a stinger, burner, or pinched nerve?	_____	_____	40. When was your first menstrual period?	_____	
			41. When was your most recent menstrual period?	_____	
			42. How much time do you usually have from the start of one period to the start of another?	_____	
			43. How many periods have you had in the last year?	_____	
			44. 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 11.8, 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: \_\_\_\_\_



## Preparticipation Physical Evaluation (Page 2 of 2)

Revised 3/08

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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: \_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_)  
 Visual Acuity: Right 20/\_\_\_\_\_, Left 20/\_\_\_\_\_, Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
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.

\_\_\_\_ 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: \_\_\_\_\_

**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.

\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA  
1960 Landings Blvd., Sarasota, FL 34231-3331

**PARENT/GUARDIAN RELEASE and HOLD HARMLESS AGREEMENT for  
MIDDLE SCHOOL STUDENT ATHLETIC PARTICIPATION**

Name of Student:	_____	SS#:	_____
Date of Birth:	_____	Place of Birth:	_____
Name of School:	_____	School Year:	_____
Sport/Activity this agreement governs (Please circle and initial all that apply):			
Golf _____	Tennis _____	Volleyball _____	Basketball _____
Track _____	Other: _____		

I/we fully understand that playing or practicing to play interscholastic sports may be hazardous and poses a risk of injury, including but not limited to, **sprains, strains, contusions, abrasions, broken bones** and in extreme cases, **paralysis or death**. Due to the potential hazards associated with interscholastic sports, I/we recognize the importance of following the instructions of coaches and trainers, regarding playing techniques, training and other rules associated with this sport/activity.

I/we understand that it is the responsibility of the parents/guardians to provide proof of medical insurance coverage prior to participating in any phase of this sport/activity.

<input type="checkbox"/> YES - I/we will be purchasing the Student Accident Insurance made available through the Sarasota School District.
<input type="checkbox"/> NO - I/we have comprehensive medical insurance that covers this student for any expenses he/she may incur as the result of a sports related injury.
Name of Insurance company: _____
Policy No.: _____ Effective Dates: _____

This agreement is entered into voluntarily and is made with the understanding that I/we have not violated any of the eligibility rules of the Sarasota School District. I/we hereby give my/our consent for my/our student/child/ward to engage in Sarasota School District approved athletic activities as a representative of his/her school. I/we give my/our consent for him/her to accompany the team on out of town/county trips.

Parent/Guardian Home Address: _____
Daytime Telephone: _____ Nighttime Telephone: _____

In consideration of the School Board of Sarasota County permitting my student/child/ward to engage in interscholastic sports, I/we agree to release and hold harmless the School Board of Sarasota County and its employees and agents from and against all claims, judgments, cost, expenses, attorney fees, including but not limited to, claims occurring from the negligence of the School Board of Sarasota County its employees and agents, arising out of bodily injuries or property damage resulting from participation in interscholastic sports.

I/we acknowledge that I/we have read this agreement and fully understand its meaning, and that I/we will abide by all terms and conditions associated with this sport/activity and in this agreement.

Parent/Guardian Signature _____	Notary Public Signature _____
Parent/Guardian Signature _____	STATE OF FLORIDA
	COUNTY OF SARASOTA
	Witness my hand and official seal this
Student Signature _____	_____ day of _____, 20____

RET: Master, 4FY  
Dupl., 1FY

027-01-DIS  
Eff. 10/2001, Rev. 04/2003