



Preparticipation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school.

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.

Table with 4 columns: Question, Yes, No, Question, Yes, No. Contains 44 medical history questions and a list of body parts to check for injuries.

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: _____



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Part 3. Physical Examination (to be completed by physician).

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 _____

Table with 4 columns: FINDINGS, NORMAL, ABNORMAL FINDINGS, INITIALS*. Rows include MEDICAL (Appearance, Eyes/Ears/Nose/Throat, Lymph Nodes, Heart, Pulses, Lungs, Abdomen, Genitalia, Skin) and MUSCULOSKELETAL (Neck, Back, Shoulder/Arm, Elbow/Forearm, Wrist/Hand, Hip/Thigh, Knee, Leg/Ankle, Foot).

* - station-based examination only

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.
___ Not cleared for: _____ Reason: _____

___ Cleared after completing evaluation/rehabilitation for: _____
___ Referred to _____ For: _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____
Address: _____

Signature of Physician: _____, 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.
___ 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