Discovery Academy of Lake Alfred

Preparticipation Physical Evaluation (Page 1 of 2)

(Athletic Physicals in Polk County Public Schools are valid from June 1 - May 31)

MUST BE TURNED IN DIRECTLY TO ATHLETIC DIRECTOR

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
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 non-prescription (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, pollen, latex, 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 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, blisters or pressure sores)?		
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?		
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 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)?		
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?		
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. Have you ever been diagnosed with sickle cell anemia?		
40. Have you ever been diagnosed with having the sickle cell trait?		

If yes, check appropriate blank and explain below:

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

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

Tetanus:_____ Measles:_____

Hepatitus 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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Preparticipation Physical Evaluation (Page 2 of 2)

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PART 1 & 2 MUST BE COMPLETED/SIGNED BEFORE PHYSICAL EVALUATION.

Revised 4/12

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/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: _____