OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES

MIDDLE SCHOOL ATHLETIC CONFERENCE PRE-PARTICIPATION PHYSICAL EVALUATION

This completed form must be kept on file at the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.
This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

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:__________ City:__________ Zip:________ 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.

Question		Question	
1.Have you had a medical illness or injury since your last check up or sports physical?	YES / NO	26. Have you ever become ill from exercising in the heat?	Yes / N0
2. Do you have an ongoing chronic illness?	YES / NO	27. Do you have a cough, wheeze or have trouble breathing during or after activity?	Yes / No
3. Have you ever been hospitalized overnight?	YES /NO	28. Do you have asthma?	
4. Have you ever had surgery?	YES / NO	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 pill or using an inhaler?	YES / NO	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?	YES /NO	31. Have you ever had any problems with your eyes or vision?	
7. Do you have any allergies for example, pollen, latex, medicine, food or stinging insects?	YES / NO	32. Do you wear glasses, contacts or protective eyewear?	
8. Have you ever had a rash or hives develop during or after exercising?	YES / NO	33. Have you ever had a sprain, strain, or swelling after injury?	
9. Have you ever passed our during or after exercise?	YES /NO	34. Have you ever broken or fractured any bones or dislocated any joints?	
10. Have you ever been dizzy during or after exercise?	YES / NO	35. Have you ever had any other problems with pain or swelling in muscles, tendons, bones or joints? *If yes, check appropriate blank and explain below:* ___Head ___Elbow ___Hip ___Back ___Neck ___Shin/Calf ___Forearm ___Thigh ___Wrist ___Knee ___Shoulder ___Chest ___Hand ___Finger ___Ankle ___Upper Arm ___Foot	
11. Have you ever had chest pain during or after exercise?	YES / NO	36. Do you want to weigh more or less than you do now?	
12. Do you get tired more quickly than your friends do during exercise?	YES /NO	37. Do you lose weight regularly to meet weight requirements for your sport?	
13. Have you ever had racing of your heart or skipped heartbeats?	YES / NO	38. Do you feel stressed out?	
14. Have you had high blood pressure or high cholesterol?	YES / NO	39. Have you ever been diagnosed with having sickle cell anemia?	
15. Have you ever been told you have a heart murmur?	YES /NO	40. Have you ever been diagnosed with having the sickle cell trait?	
16. Has any family member of relative died of heart problems or sudden death before age 50?	YES / NO	41. Record the dates of your most recent immunizations (shots for: Tetanus__________ Measles__________ Hepatitis B__________ Chickenpox__________	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	YES / NO	FEMALES ONLY (OPTIONAL) 42. When was your first menstrual period?	
18. Has a physician ever denied or restricted your participation in sports for any heart problem?	YES /NO	43. When was your most recent menstrual period?	
19. Do you have any current skim problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores?	YES / NO	44. How much time do you usually have from the start of one period to the start of another?	
20. Have you ever had a head injury or concussion?	YES / NO	45. How many periods have you had in the last year?	
21. Have you ever been knocked out, become unconscious or lost your memory?	YES /NO	46. What was the longest time between periods in the last year:	
22. Have you ever had a seizure?	YES / NO	Explain "yes answers here: __________	
23. Do you have frequent or sever headaches?	YES / NO		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	YES /NO		
25. Have you ever had a stinger, burner or pinched nerve?	YES / NO		

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, we understand and acknowledge that we are hereby advised that the student should undergo 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 ____/____/____
(WHERE DIVORCED OR SEPARATED, PARENT/GUARDIAN WITH LEGAL CUSTODY MUST SIGN)

MIS 6347
Rev. 1.13.2021

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION

This completed form must be kept on file at 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 osteopathic physician, licensed chiropractic physician, licensed physician or certified advanced medicine 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

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:** ______________________

______ **Cleared after completing evaluation/rehabilitation for:** ______________________ **For:** __________

Recommendations: ______________________

Name of Physician/Physician Assistant/Nurse Practitioner (print): ______________________

Address: ______________________ **City:** ______________________ **Zip:** __________

______________________________ ______________________

SIGNATURE OF PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER DATE