

**Pre-Participation Physical Evaluation**  
**This form is to be completed by Student and Parent**  
**2010/2011**

Part 1 - Student Information

Student's name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth; \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_

(Father) Work Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell# \_\_\_\_\_

(Mother) Work Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell# \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Contact#: ( ) \_\_\_\_\_

Family Physician: \_\_\_\_\_ City/State: \_\_\_\_\_

Physician Office Phone: ( ) \_\_\_\_\_

Part 2 – Medical History - Explain “yes” answers below. Circle questions if you don't know the answer. Include all meds that you carry on you; prescribed medications, epinephrine, allergies, diabetes, etc.

- 1) Date of last full physical exam: \_\_\_/\_\_\_/\_\_\_ (previous to today's date) YES NO
- 2) Have you had a medical illness or injury since your last check up or sports physical? YES NO
- 3) Do you or anyone in your family have/had:
- |                              |     |    |  |
|------------------------------|-----|----|--|
| a. heart/vessel disease?     | YES | NO |  |
| b. kidney/liver problems?    | YES | NO |  |
| c. strokes or CVAs?          | YES | NO |  |
| d. diabetes?                 | YES | NO |  |
| e. epilepsy?                 | YES | NO |  |
| f. sickle cell trait/anemia? | YES | NO |  |
- 4) Are you currently taking any prescription or non-prescription medication, pills or using an inhaler?  
This includes all medications required by student during physical activity i.e. allergy, diabetes, epinephrine, Rx, etc. YES NO
- 5) Do you have or have you ever had:
- |                                  |     |    |  |     |    |
|----------------------------------|-----|----|--|-----|----|
| a. an ongoing illness?           | YES | NO | l. racing of your heart or skipped heartbeats?                                   | YES | NO |
| b. overnight hospitalization?    | YES | NO | m. high blood pressure or high cholesterol?                                      | YES | NO |
| c. surgery?                      | YES | NO | n. a head injury, concussion, lost consciousness,<br>or lost memory?             |     |    |
| d. any allergies                 | YES | NO | o. numbness or tingling in your arms, hands,<br>legs or feet?                    | YES | NO |
| e. a heart murmur?               | YES | NO | p. a stinger, burner or pinched nerve?   | YES | NO |
| f. a severe viral infection?     | YES | NO | q. difficulty with exercising in the heat?                                       | YES | NO |
| g. any current skin problems?    | YES | NO | r. a sprain, strain, or swelling after injury?                                   | YES | NO |
| h. a seizure?                    | YES | NO | s. any broken/fractured bones/dislocated joints?                                 | YES | NO |
| i. frequent or severe headaches? | YES | NO | t. any other problems with pain/swelling in muscles, bones<br>tendons or joints? | YES | NO |
| j. asthma?                       | YES | NO |  |     |    |
| k. problems with eyes or vision? | YES | NO |  |     |    |

(Continued on reverse side)

- 6) During or after exercise, do you or have you ever:
    - a. been dizzy or passed out? YES NO
    - b. had chest pain? YES NO
    - c. cough, wheeze, or have trouble breathing? YES NO
    - d. tire more quickly than your friends do? YES NO
  - 7) Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO
  - 8) Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? YES NO
  - 9) Do you have any unusual reactions to heat or cold? YES NO
  - 10) Do you lose weight regularly to meet weight requirements for your sport? YES NO
  - 11) Have you ever taken any supplements to help you gain or lose weight or improve your performance? YES NO
  - 12) Do you drink "energy drinks" before practice or games? YES NO
- MALES ONLY*
- 13) Have you ever had testicular surgery or only have one testicle? YES NO

Please explain "YES" answers here. (Place # from above first, letter and explanation):

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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.

\_\_\_\_\_  
Student Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

Date: \_\_\_\_\_