

**OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES**  
**MIDDLE SCHOOL ATHLETIC CONFERENCE PRE-PARTICIPATION PHYSICAL EVALUATION**

**PAGE 1 OF 3**

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.**

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 / NO
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 out 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? <i>If yes, check appropriate blank and explain below:</i> ___ 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	<b>FEMALES ONLY (OPTIONAL)</b>	
18. Has a physician ever denied or restricted your participation in sports for any heart problem?	YES /NO	42. When was your first menstrual period?	
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	YES / NO	43. When was your most recent menstrual period?	
20. Have you ever had a head injury or concussion?	YES / NO	44. How much time do you usually have from the start of one period to the start of another?	
21. Have you ever been knocked out, become unconscious or lost your memory?	YES /NO	45. How many periods have you had in the last year?	
22. Have you ever had a seizure?	YES / NO	46. What was the longest time between periods in the last year:	
23. Do you have frequent or severe headaches?	YES / NO	Explain "yes answers here: _____	
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	YES /NO	_____	
25. Have you ever had a stinger, bumer 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)

**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
<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 :**

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