

Part 1. Student Information (to be completed by student or parent)

Student's Name:			Sex	k: Ag	e: Date of Bir	th:/
School:			Sport(s):			
Home Address:					Home Phone: (_)	
Name of Parent/Guardian:			E-ma	ail:		
Person to Contact in Case of Emergency:						
Relationship to Student:	Home Phone: ()	Work Phone: (_)	Cell Phone: (_)	
Personal/Family Physician:		City/Stat	e:		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.

check up or sports physical? 27. Do you cough, wheeze or have trouble breathing during or after activity? 28. Ja Have you ever head nospinalized overnight? 28. Do you have a sathma? 29. Do you have a work peen hospinalized overnight? 28. Do you have a sathma? 29. Do you have serve thad surgery? 29. Do you have a sathma? 29. Do you have serve that surgery? 29. Do you have a symplement or medical devices that aren't usually used for your sport or position (for example, net protective or corrective equipment or medical devices that aren't usually used for your sport or position? 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? 31. Have you ever had a straing addr)? 7. Do you have any allergies (for example, pellen, latex, medicine, food or stinging insects)? 34. Have you helen or fractured any pones or dislocated any joints? 8. Have you ever had a strain arsh or hives develop during or after exercise? 31. Have you ever had as any sing an induring or after exercise? 9. Have you ever based out during or after exercise? 35. Have you bene or joints? 11. Have you ever had chep tain during or after exercise? 35. Have you have weight met on swelling in muscles, tendons, bones or joints? 12. Do you get tired more quickly than your friends do during exercise? Most weight met or less than you do now? 13. Have you ever had chest paint faction (for example, heatrothems?) 36. Have you ever h			res	INO					168	140
2. Do you have an ongoing chonic illness? activity? 3. Have you ever been hospitalized overnight? 28. Do you have ashma? 4. Have you ever had surgery? 29. Do you have ashma? 5. Are you currently taking any prescription or non-prescription (over-the-context) medical diverse that arequire medical treatment? 30. Do you use any special protective or corrective equipment or medical diverse that arequire medical diverse that arequire medical treatment? 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? 31. Have you ever had any problems with your eyes or vision? 7. Do you have any allergies (for example, pollen, latex, medical devices that arequire any source the or hearing gait)? 31. Have you ever had a rash or hives develop during or after exercise? 8. Have you ever based out during or after exercise? 35. Have you ever head argo ther problems with pain or swelling after injury? 31. Have you ever been dizzy during or after exercise? 33. Have you ever head argo ther problems with pain or swelling in muscles, trendons, hones or joints? 71. Have you had high holod pressure or high cholesterol? 36. Do you want to weigh more or less than you do now? 33. Have you ever been dizzy during or after exercise? 36. Do you want to weigh more or less than you do now? 34. Have you ever head argo for manner. 36. Do you have any allergies (for example, myocarditis or mononucleosis) within the last month? 34. Have y	1.	Have you had a medical illness or injury since your last								
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4. Have you ever had surgery? 29. Do you have esaconal allergies that require medical treatment? 5. Are you eurendly taking any prescription or non- prescription (over-the-counter) medications or pills or using an inhaler? 30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for yours spont or position (for example, knee braces, special neck roll, foot orthotics, shunt, retainer on your tech or hearing aid)? 1. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? 31. Have you wear glasses, contacts or protective eyewar? 2. Do you wave glasses, contacts or protective eyewar? 33. Have you ever had a sprain, strain or swelling after injury? 3. Have you ever had ansh or hives develop during or after exercise? 34. Have you over had a sprain, strain or swelling in muscles, indons, bones or joints? 1. Have you ever baen dizzy during or after exercise?					20		0			
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	25.	Have you ever had a stinger, burner or pinched nerve?			40.	what was the long	gest time between	perious in the last year?		
	Ext	blain "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.



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						<u>/(</u> /,)
Temperature:H Visual Acuity: Right 20/		Fleft: P Corrected: Yes	F No	Pupils: Equal	Unequal	_	
FINDINGS	NORMAL			ABNORMAL FIN	DINGS		INITIALS*
MEDICAL							
1. Appearance							
2. Eyes/Ears/Nose/Throat		. <u></u>					
3. Lymph Nodes							
4. Heart		. <u></u>					
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 of	nly						

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:				



Student's Name:

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		
Disability:	Diagnosis:	
Precautions:		
Not cleared for:	Reason:	
Cleared after completing evaluation/rehabilitation for:		
Recommendations:		
Name of Physician (print):		Date: / /
Address:		

Signature of Physician:

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.