

THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

Form# 301
Rev 04/08
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Martin County School District Pre-Participation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

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: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone Number: (____) _____ Work Phone Number: (____) _____
 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		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	27. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	30. 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)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any allergies (i.e. to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate blank and explain below:</i>		
12. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	___ Head	___ Elbow	___ Hip
13. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	___ Neck	___ Forearm	___ Thigh
14. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	___ Back	___ Wrist	___ Knee
15. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	___ Chest	___ Hand	___ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	___ Ankle	___ Finger	___ Shoulder
17. Have you had a severe viral infection (i.e. myocarditis, or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	___ Foot	___ Upper Arm	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	36. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	37. Do you lose weight regularly to meet weight requirement for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	39. Record the dates or your most recent immunizations (shots) for: Tetanus: _____ Measles: _____ Hepatitis B: _____ Chickenpox: _____		
22. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY (Optional)		
23. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	40. When was your first menstrual period? _____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	41. When was your most recent menstrual period? _____		
25. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	42. How much time do you usually have from the start of one period to the start of another? _____		
			43. How many periods have you had in the last year? _____		
			44. 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 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.

Signature of Student: _____ Date: _____ Signature of Parent/Guardian: _____ Date: _____

White: School Athletic Office

Yellow: Coach

Pink: Parent

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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: ____/____ (____/____, ____/____)

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
- Cleared after completing evaluation/rehabilitation for: _____
- Not cleared for: _____ Reason: _____
- Referred to: _____

Recommendations: _____

Name of Physician/ Physician Assistant/ Nurse Practitioner (print or type): _____ Date: _____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (IF APPLICABLE)

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
 - Cleared after completing evaluation/rehabilitation for: _____
 - Not cleared for: _____ Reason: _____
- Recommendations: _____

Name of Physician (print or type): _____ 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.