THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

Martin County School District Pre-Participation Physical Evaluation For Middle Schools Only

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
1. Have you had a medical illness or injury since your last check up or sports physical?	□	□
2. Do you have an ongoing chronic illness?	□	□
3. Have you ever been hospitalized overnight?	□	□
4. Have you ever had surgery?	□	□
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	□ □	□ □
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	□	□
7. Do you have any allergies (i.e. to pollen, medicine, food, latex or stinging insects)?	□	□
8. Have you ever had a rash or hives develop during or after exercise?	□	□
9. Have you ever passed out during or after exercise?	□	□
10. Have you ever been dizzy during or after exercise?	□	□
11. Have you ever had chest pain during or after exercise?	□	□
12. Do you get tired more quickly than your friends do during exercise?	□	□
13. Have you ever had racing of your heart or skipped heartbeats?	□	□
14. Have you had high blood pressure or high cholesterol?	□	□
15. Have you ever been told you have a heart murmur?	□	□
16. Has any family member or relative died of heart problems or sudden death before age 50?	□	□
17. Have you had a severe viral infection (i.e. myocarditis, or mononucleosis) within the last month?	□	□
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	□	□
19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters or pressure sores?)	□ □	□ □
20. Have you ever had a head injury or concussion?	□	□
21. Have you ever been knocked out, become unconscious, or lost your memory?	□	□
22. Have you ever had a seizure?	□	□
23. Do you have frequent or severe headaches?	□	□
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	□	□
25. Have you ever had a stinger, burner, or pinched nerve?	□	□
26. Have you ever become ill from exercising in the heat?	□	□
27. Do you cough, wheeze, or have trouble breathing during or after activity?	□	□
28. Do you have asthma?	□	□
29. Do you have seasonal allergies that require medical treatment?	□	□
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,shunt, retainer on your teeth, hearing aid)?	□	□
31. Have you had any problems with your eyes or vision?	□	□
32. Do you wear glasses, contacts or protective eyewear?	□	□
33. Have you ever had a sprain, strain or swelling after injury?	□	□
34. Have you broken or fractured any bones or dislocated any joints?	□	□
35. Have you 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 ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf ___ Ankle ___ Finger ___ Shoulder ___ Foot ___ Upper Arm		
36. Do you want to weigh more or less than you do now?	□	□
37. Do you lose weight regularly to meet weight requirement for your sport?	□	□
38. Do you feel stressed out?	□	□
39. Have you ever been diagnosed with Sickle Cell Anemia?	□	□
40. Have you ever been diagnosed with having sickle cell trait?	□	□

41. Record the dates of your most recent immunizations for:
Tetanus: _____ Measles_____Hepatitis B_____Chickenpox _____

FEMALES ONLY (Optional)

42. When was your first menstrual period? _____
43. When was your most recent menstrual period? _____
44. How much time do you usually have from the start of one period to the start of another? _____
45. How many periods have you had in the last year? _____
46. 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, 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

Martin County School District Pre-Participation Physical Evaluation

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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.