

**Bay District Schools
Athletic Physical Examination Form**

This form is good for one calendar year from the date of the Physician signature

PART 1. STUDENT INFORMATION

Student Name _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 Home Address _____ Home Phone (____) _____
 School: _____ Grade in School: _____ School Sport(s): _____
 Name of Parent/Guardian: _____ Relationship to Student: _____
 Parent's Home Phone: (____) _____ Parent's Work Phone: (____) _____ Parent's Cell Phone: (____) _____
 Personal/Family Physician: _____ City/State _____ Physician's Office Phone: (____) _____

PART 2. MEDICAL HISTORY Circle Y for YES and N for NO for the following questions:

1. Have you had a medical illness or injury since your last check up or sports physical? Y N
2. Do you have an ongoing chronic illness? Y N
3. Have you been hospitalized overnight? Y N
4. Have you ever had surgery? Y N
5. Are you currently taking any prescription or non-prescription (over the counter medications), pills or using an inhaler? Y N
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Y N
7. Do you have allergies (pollen, medicine, food, or stinging insects)? Y N
8. Have you ever had a rash or hives develop during or after exercise? Y N
9. Have you ever passed out during/after exercise? Y N
10. Have you ever been dizzy during/after exercise? Y N
11. Have you ever had chest pains during/after exercise? Y N
12. Do you get tired more quickly than your friends during exercise? Y N
13. Have you ever had racing or skipping of your heartbeats? Y N
14. Have you had high blood pressure/cholesterol? Y N
15. Have you been told you have a heart murmur? Y N
16. Has any family members/relative died of heart problems or sudden death before age 50? Y N
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Y N
18. Has a physician ever denied or restricted your participation in sports for any heart problems? Y N
19. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)? Y N
20. Have you ever had a head injury or concussion? Y N
21. Have you ever been knocked out, become unconscious or lost your memory? Y N
22. Have you ever had a seizure? Y N
23. Do you have frequent or severe headaches? Y N
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Y N
25. Have you ever had a stinger, burner, or pinched nerve? Y N
26. Have you ever become ill from exercising in the heat? Y N
- during or after activity? Y N

27. Do you cough, wheeze or have trouble breathing
 28. Do you have asthma? Y N
 29. Do you have seasonal allergies that require medical treatment? Y N
 30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or a hearing aid)? Y N
 31. Do you have any problems with your eyes or vision? Y N
 32. Do you wear glasses, contacts, or protective eyewear? Y N
 33. Have you ever had a sprain, strain, or swelling after injury? Y N
 34. Have you broken or fractured any bones or dislocated any joints? Y N
 35. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? Y N
- If yes, mark appropriate ones and explain below**.
- | | | |
|---------------|--------------|---------------|
| ___ Head | ___ Neck | ___ Back |
| ___ Chest | ___ Shoulder | ___ Upper Arm |
| ___ Elbow | ___ Forearm | ___ Wrist |
| ___ Hand | ___ Finger | ___ Foot |
| ___ Hip | ___ Thigh | ___ Knee |
| ___ Shin/Calf | ___ Ankle | |
36. Do you want to weigh more or less than you do now? Y N
 37. Do you lose weight regularly to meet weight requirements for your sport? Y N
 38. Do you feel stressed out? Y N
 39. Record the dates of your most recent immunizations (shots) for:
 Tetanus: _____ Measles: _____
 Hepatitis B: _____ Chickenpox: _____
- **Explain Yes" answers here: _____

- Females Only (Optional)**
40. When was your first menstrual period? (year) _____
 41. When was your most recent menstrual period? _____
 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? _____

We hereby state, that, to the best of my 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

Signature of Student: _____
 Signature of Parent: _____

Date: _____
 Date: _____

PART 3. PHYSICAL EXAMINATION (to be completed by physician)

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 _____

MEDICAL FINDINGS	NORMAL	ABNORMAL FINDINGS	*INITIALS
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/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s):

_____ Cleared without limitation.
_____ Not Cleared for: _____ Reason: _____

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Referred to: _____ For _____

Recommendations: _____

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

Address _____ Signature of Physician/Nurse Practitioner: _____

ASSESSMENT OF REFERRED PHYSICIAN (IF APPLICABLE)

I hereby certify that the examination(s) for which referred was/were performed by me or an individual under my direct supervision with the following conclusion(s)

_____ Cleared without limitation.
_____ Not cleared for: _____ Reason: _____

_____ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Referred Physician (print or type): _____ Date _____

Address: _____

Signature of Physician: _____