

PREPARTICIPATION PHYSICAL EVALUATION (Page $1\ of\ 4$)

This medical history form should be retained by the healthcare provider and/or parent. Athletic Physicals in Polk County Public Schools are valid for the academic school year only.

EL2

Revised 3/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) print legibly

		Completed by stadent and		Cov Acciana	ed at Birth: Age:	Date of Birth:	/_	_/	
Schoo	ol:			Grade in Sc	chool:Sport(s): Home Phone: () to Student: Other Phone				
Home	Address:	Ci	ty/State:		Home Phone: () _				
Name	of Parent/Guardian:			E-mail:					
Perso	n to Contact in Case of Er	nergency:		_ Relationship t	to Student:	·			
Emer	gency Contact Cell Phone	: ()	Work Phone	:: ()	Office Phone	e: ()			
Family	y Healthcare Provider:		City/State.		Office Phone				
Stude	11(10#						Encina Charles Sur		
List pa	ast and current medical c	onditions:							
Have	you ever had surgery? If y	yes, please list all surgical pro	ocedures and d	ates:					
Medio	cines and supplements (p	lease list all current prescrip	tion medication	ns, over-the-co	unter medicines, and supple	ments (herbal	and nutr	ritional):	
Do yo	u have any allergies? If ye	es, please list all of your aller	gies (i.e., medi	cines, pollens,	food, insects):	<u> </u>		***************************************	
Patier	nt Health Questionaire ve	e <mark>rsion 4 (PHQ-4)</mark> often have you been bothere	ed by any of the	e followina prol	blems? (Circle response)				
Over a	the past two weeks, now	Not at all	· ·	al days	Over half of the days	Nearly	y everyda	av	
100		IVOC at all						500000000000000000000000000000000000000	
	ng nervous, anxious, n edge	0		1	2		3		
	peing able to stop or soloworrying	0		1	2		3		
Little	interest or pleasure	0		1	2		3		
3 158 503	oing things ing down, depressed,			1	2		3		
102000000000	opeless o	0		1	2	<u> </u>			
	ERAL QUESTIONS			2019 2010 000 000 000 000 000 000 000	TH QUESTIONS ABOUT YOU		Yes	No.	
Expla Circle	in "Yes" answers at the end equestions if you don't know		Yes No	(continued)					
Do you have any concerns that you would like to discuss with your provider?				8 example, (ECHO)?	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?				
2	Has a provider ever denied or r sports for any reason?	restricted your participation in			et light-headed or feel shorter of bre uring exercise?	ath than your			
3	Do you have any ongoing medi	ical issues or recent illnesses?		10 Have you	ever had a seizure?				
HEA	RT HEALTH QUESTIONS A		Yes No		TH QUESTIONS ABOUT YOU	September 1990 Commence	Yes	No	
4	Have you ever passed out or ne exercise?	early passed out during or after		11 had an u	family member or relative died of hea nexpected or unexplained sudden de uding drowning or unexplained car ca	ath before age			
5	Have you ever had discomfort, your chest during exercise?	pain, tightness, or pressure in		as hyperi	vone in your family have a genetic he trophic cardiomyopathy (HCM), Marf rogenic right ventricular cardiomyops syndrome (LQTS), short QT syndrome	an Syndrome, athy (ARVC),			
6	Does your heart ever race, flutt (irregular beats) during exercise			syndrom	e, or catecholaminerige polymorphic dia (CPVT)?				
7	Has a doctor ever told you that	t you have any heart problems?			one in your family had a pacemaker o tor before age 35?	r an implanted			



Student's Full Name:

tests listed above.

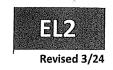
PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

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Date of Birth:

School:



Primer-			MINORUS III III III III III III III III III I				
ВО	NE AND JOINT QUESTIONS	Yes	No	ME	DICAL QUESTIONS (continued)	Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		·
MEI	DICAL QUESTIONS	Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Exp	lain "Yes" answers here:		Marie Paris Control Paris Cont
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			-			PARTICLE STATE OF THE STATE OF
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			-			
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?						
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					*****************	
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					***************************************	WARRANT - 1824
23	Have you ever become ill while exercising in the heat?						
24	Do you or does someone in your family have sickle cell trait or disease?						
25	Have you ever had or do you have any problems with your eyes or vision?						***************************************
					s all sections are complete.		
above injurie prepa each	e questions allows for a trained clinician to asse es and death. Florida Statute 1006.20 requires rticipation physical evaluation as the first step	ss the ir a studer of injur nletic co	ndividua nt candi y preve ompetiti	l stud date f ntion. on or	e and parent/guardian acknowledge truthful a ent-athlete against risk factors associated with some an interscholastic athletic team to successful This preparticipation physical evaluation shall engaging in any practice, tryout, workout, collyear.	sports-r Ily comp be com	elated plete a pleted
the rower are also the contract of the contrac	outine physical evaluation required by Florida e hereby advised that the student should un ocardiogram (ECG), echocardiogram (ECHO), a	Statute dergo a nd/or ca	e 1006.2 cardiov ardio str	20, ar /ascul ess te	e above questions are complete and correct. In the standard and acknown ar assessment, which may include such diagnost. The FHSAA Sports Medicine Advisory Commeters of sudden cardiac arrest which may include the sudden cardiac arrest which was a sudden cardiac arrest which may include the sudden cardiac arrest which was a sudden cardiac arrest was a sudden cardiac arrest which was a sudden cardiac arrest was a sudden car	owledg ostic te nittee st	e that ests as rongly

Parent/Guardian Name: ______ (printed) Parent/Guardian Signature: _____ Date: __/ __/

Parent/Guardian Name: ______(printed) Parent/Guardian Signature: ______ Date: __/ __/



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

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PHYSICAL EXAMINATION FORM

Student's Full Name:	Date of Birth:	/ School:	
HEALTHCARE PROFESSIONAL REMINDERS:			
Lonsider additional questions on more sensitive issues. • Do you feel stressed out or under a lot of pressure?	Do you ever fe	el sad, hopeless, depressed, or a	anxious?
Do you feel safe at your home or residence?	During the pas	t 30 days, did you use chewing t	obacco, snuff, or dip?
Do you drink alcohol or use any other drugs?	Have you ever supplement?	taken anabolic steroids or used	any other performance-enhancing
 Have you ever taken any supplements to help you gain or lose weight or improve y performance? 		experienced performance chan mes of low energy during the pa	
Verify completion of FHSAA EL2 Medical History (pages 1 and 2) Cardiovascular history/symptom questions include Q4-Q13 of N), review these medica Medical History form. (al history responses as pa (check box if complete)	art of your assessment.
EXAMINATION			
Height: Weight:		AND THE RESIDENCE OF THE PARTY	
BP: / (/) Pulse: Vision: R 2	.0/ L 20/		Yes No
MEDICAL - healthcare professional shall initial each assessment		NORMAL	. ABNORMAL FINDINGS
 Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnode prolapse [MVP], and aortic insufficiency) 	actyl, hyperlaxity, myopia, m	nitral valve	
Eyes, Ears, Nose, and Throat . • Pupils equal • Hearing			
Lymph Nodes			
Heart Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)			
Lungs			
Abdomen			
Skin Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococ	ccus Aureus (MRSA), or tinea	a corporis	
Neurological MUSCULOSKELETAL - healthcare professional shall initial each asse	ssment	NORMAL	. ABNORMAL FINDINGS
Neck			
Back			
Shoulder and Arm			
Elbow and Forearm			
Wrist, Hand, and Fingers			
Hip and Thigh			
Knee			
Leg and Ankle	<u> </u>		AND THE RESIDENCE OF THE PARTY
Foot and Toes	uncescent and a second a second and a second a second and		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test			
This form is not considered va	alid unless all sectio	ons are complete.	
Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for ab Ivisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with	onormal cardiac history or exa h your healthcare provider for	amination findings, or any combir risk factors of sudden cardiac arre	nation thereof. The FHSAA Sports Medicin est which may include an electrocardiogram
ame of Healthcare Professional (print or type):		Da	ate of Exam://
ddress: Phone: () _		E-mail:	
gnature of Healthcare Professional:	Crede	ntials:	License #:

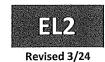
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and/or cardio stress test.

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL



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MEDICAL ELIGIBILITY FORM

Student's Full Name:	ship to Student:sp Home Pho ship to Student: ader Florida chapter 45. (§1006.20(2)(c), F.S.)	Ort(s): One: () Other Phone: () Office Phone: () 8, chapter 459, chapter 460	, §464.012, or
Home Address:	Home Pho	Other Phone: () Office Phone: () S, chapter 459, chapter 460	o, §464.012, or
Name of Parent/Guardian:	nship to Student: nder Florida chapter 45. (§1006.20(2)(c), F.S.)	_ Other Phone: () _ Office Phone: () _ 8, chapter 459, chapter 460	, §464.012, or
Person to Contact in Case of Emergency:	nder Florida chapter 45 (§1006.20(2)(c), F.S.)	Other Phone: () _ Office Phone: () _ 8, chapter 459, chapter 460	, §464.012, or
Family Healthcare Provider: City/State: Student ID#: The preparticipation physical evaluation must be administered by a practitioner licensed un registered under §464.0123, and in good standing with the practitioner's regulatory board. Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation with the practition with recommendations for further evaluation. Medically eligible for only certain sports as listed below:	nder Florida chapter 45 (§1006.20(2)(c), F.S.)	_ Office Phone: () 8, chapter 459, chapter 460	, §464.012, or
Family Healthcare Provider: City/State: Student ID#: The preparticipation physical evaluation must be administered by a practitioner licensed un registered under §464.0123, and in good standing with the practitioner's regulatory board. Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation of the provided in the practition with recommendations for further evaluation. Medically eligible for only certain sports as listed below:	nder Florida chapter 45 (§1006.20(2)(c), F.S.)	_ Office Phone: () 8, chapter 459, chapter 460	, §464.012, or
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 ✓ Medically eligible for all sports without restriction with recommendations for further expenses. ✓ Medically eligible for only certain sports as listed below: ✓ Not medically eligible for any sports 	raluation or treatment o	of: (use additional sheet, if n	ecessary)
☐ Medically eligible for only certain sports as listed below: ☐ Not medically eligible for any sports	aluation or treatment o	f: (use additional sheet, if n	ecessary)
□ Not medically eligible for any sports			
		and a grant control of the control o	
Recommendations: (use additional sheet, if necessary)			
by the parent as requested. Any injury or other medical conditions that arise evaluated, diagnosed, and treated by an appropriate healthcare professional price. Name of Healthcare Professional (print or type):	or to participation in a	activities. Date	://
Address:		Phone: ()	
Signature of Healthcare Professional:	Credentials:	License #:	
SHARED EMERGENCY INFORMATION - completed at the time of assessment by	practitioner and par	ent	
Check this box if there is no relevant medical history to share related to participation in competitive sports.	Provi	ider Stamp (if required by	r school)
Medications: (use additional sheet, if necessary)			
List:			
Relevant medical history to be reviewed by athletic trainer/team physician: (explain	n below, use addition	al sheet, if necessary)	
☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness	☐ Orthopedic ☐ Sur	rgical History 🗖 Sickle Ce	ll Trait 🔲 Other
Explain:			
Signature of Student: Date:/ Signature of Pa	rent/Guardian:		Date: / /
We hereby state, to the best of our knowledge the information recorded on this form is co			

This form is not considered valid unless all sections are complete.

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