

OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES
MIDDLE SCHOOL ATHLETIC CONFERENCE PRE-PARTICIPATION PHYSICAL EVALUATION

PAGE 1 OF 3

This completed form must be kept on file at 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: _____ City: _____ Zip: _____ Home phone:(____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone:(____) _____ Work Phone:(____) _____ Cell Phone:(____) _____
 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.

- | | | | |
|---|----------|--|---------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | Yes / No | 26. Have you ever become ill from exercising in the heat? | Yes/No |
| 2. Do you have an ongoing chronic illness? | Yes/No | 27. Do you have a cough, wheeze, or have trouble breathing during or after activity? | Yes/No |
| 3. Have you ever been hospitalized overnight? | Yes/No | 28. Do you have asthma? | Yes/No |
| 4. Have you ever had surgery? | Yes/No | 29. Do you have seasonal allergies that require medical treatment? | Yes/No |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | Yes/No | 30. Do you use any special protective or corrective equipment medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt retainer on your teeth or hearing aid)? | Yes/No |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | Yes/No | 31. Have you had any problems with your eyes or vision? | Yes/No |
| 7. Do you have any allergies for example, pollen, latex, medicine, food or stinging insects? | Yes/No | 32. Do you wear glasses, contacts or protective eyewear? | Yes/No |
| 8. Have you ever had a rash or hives develop during or after exercising? | Yes/No | 33. Have you ever had a sprain, strain, or swelling after injury? | Yes/No |
| 9. Have you ever passed out during or after exercise? | Yes/No | 34. Have you ever broken or fractured any bones or dislocated any joints? | Yes/No |
| 10. Have you ever been dizzy during or after exercise? | Yes/No | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | |
| 11. Have you ever had chest pain during or after exercise? | Yes/No | <i>If yes check appropriate blank and explain below:</i> | |
| 12. Do you get tired more quickly than your friends do during exercise? | Yes/No | ___ Head | ___ Elbow |
| 13. Have you ever had racing of your heart or skipped heartbeats? | Yes/No | ___ Hip | ___ Back |
| 14. Have you had high blood pressure or high cholesterol? | Yes/No | ___ Neck | ___ Forearm |
| 15. Have you ever been told you have a heart murmur? | Yes/No | ___ Thigh | ___ Wrist |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | Yes/No | ___ Chest | ___ Hand |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | Yes/No | ___ Hand | ___ Finger |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | Yes/No | ___ Ankle | ___ Upper Arm |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? | Yes/No | ___ Foot | |
| 20. Have you ever had a head injury or concussion? | Yes/No | 36. Do you want to weigh more or less than you do now? | Yes/No |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | Yes/No | 37. Do you lose weight regularly to meet weight requirements for your sport? | Yes/No |
| 22. Have you ever had a seizure? | Yes/No | 38. Do you feel stressed out? | Yes/No |
| 23. Do you have frequent or severe headaches? | Yes/No | 39. Have you ever been diagnosed with sickle cell anemia? | Yes/No |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet? | Yes/No | 40. Have you ever been diagnosed with having the sickle cell trait? | Yes/No |
| 25. Have you ever had a stinger, burner or pinched nerve? | Yes/No | 41. Record the dates of your most recent immunizations (shots) for: | |

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 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 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 ____/____/____

(WHERE DIVORCED OR SEPARATED, PARENT/GUARDIAN WITH LEGAL CUSTODY MUST SIGN)

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION

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

Part 3. Physical Examination (to be completed by licensed osteopathic physician, licensed chiropractic physician, licensed physician or certified advanced medicine nurse practitioner).

Student's name: _____ Date of Birth ____/____/____
Height: ____ Weight: ____ % Body Fat (optional): ____ Pulse: ____ Blood Pressure: ____/____ (____/____, ____/____)
Temperature: ____ Hearing: right: P ____ F ____ left: P ____ F ____
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

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: _____

_____ Cleared after completing evaluation/rehabilitation for: _____ For: _____

_____ Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner

(print): Tracey Burton-Lindner MD
Address: 1001 W. College Blvd. - Suite C City: Niceville, FL Zip: 32578

SIGNATURE OF PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

DATE