



This completed form must be kept on file by the school.

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.

Table with 4 columns: Question, Yes, No, Question, Yes, No. Contains 38 medical history questions and a list of body parts for injury reporting.

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: \_\_\_\_\_

A COPY OF ATHLETES INSURANCE I.D. CARD MUST BE ATTACHED TO THIS FORM. ALL ATHLETES MUST HAVE INSURANCE.



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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

\_\_\_\_ Cleared without limitation.

\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_ Referred to \_\_\_\_\_ For: \_\_\_\_\_

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 the examination(s)

\_\_\_\_ Cleared without limitation.

\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

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.

PHYSICAL MUST BE TAKEN AFTER JUNE 1ST, 2008