MIS 6347
1/24/2017

OKALOOSA COUNTY SCHOOL DISTRICT/STUDENT INTERVENTION SERVICES

MIDDLE SCHOOL ATHLETIC CONFERENCE 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 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
2. Do you have an ongoing chronic illness? Yes/No
3. Have you ever been hospitalized overnight? Yes/No
4. Have you ever had surgery? Yes/No
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? Yes/No
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes/No
7. Do you have any allergies 9for example, pollen, latex, medicine, food or stinging insects? Yes/No
8. Have you ever had a rash or hives develop during or after exercising? Yes/No
9. Have you ever passes out during or after exercise? Yes/No
10. Have you ever been dizzy during or after exercise? Yes/No
11. Have you ever had chest pain during or after exercise? Yes/No
12. Do you get tired more quickly than your friends do during exercise? Yes/No
13. Have you ever had racing of your heart or skipped heartbeats? Yes/No
14. Have you had high blood pressure or high cholesterol? Yes/No
15. Have you ever been told you have a heart murmur? Yes/No
16. Has any family member or relative died of heart problems or sudden death before age 50? Yes/No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes/No
18. Has a physician ever denied or restricted your participation in sports for any heart problems? Yes/No
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores? Yes/No
20. Have you ever had a head injury or concussion? Yes/No
21. Have you ever been knocked out, become unconscious or lost your memory? Yes/No
22. Have you ever had a seizure? Yes/No
23. Do you have frequent or severe headaches? Yes/No
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes/No
25. Have you ever had a stinger, burner or pinched nerve? Yes/No
26. Have you ever become ill from exercising in the heat? Yes/No
27. Do you have a cough, wheeze, or have trouble breathing during or after activity? Yes/No
28. Do you have asthma? Yes/No
29. Do you have seasonal allergies that require medical treatment? 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
31. Have you had any problems with your eyes or vision? Yes/No
32. Do you wear glasses, contacts or protective eyewear? Yes/No
33. Have you ever had a sprain, strain, or swelling after injury? Yes/No
34. Have you ever broken or fractured any bones or dislocated any joints? Yes/No
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 ___Back ___Shin/Calf
    ___Neck ___Forearm ____Thigh ___Wrist ___Shoulder
    ___Knee ___Chest ___Hand ___Hand ___Finger
    ___Ankle ___Upper Arm ___Foot
36. Do you want to weigh more or less than you do now? Yes/No
37. Do you lose weight regularly to meet weight requirements for your sport? Yes/No
38. Do you feel stressed out? Yes/No
39. Have you ever been diagnosed with sickle cell anemia? Yes/No
40. Have you ever been diagnosed with having the sickle cell trait? Yes/No
41. Record the dates of your most recent immunizations (shots) 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 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)

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ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION

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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):_____

Address: _____City: _____Zip:_____

_____ _____

SIGNATURE OF PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER DATE

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(if applicable)
ASSESSMENT OF PHYSICIAN TO WHO REFERRED

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

_____ Disability: _____ Diagnosis: _____

_____

_____Precautions: _____

_____

_____Not cleared for: _____Reason: _____

_____Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print): _____

Address: _____ City: _____ Zip: _____

_____ _____

Signature of Physician **Date**

Based on recommendations developed by the American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.