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Ahfachkee Athletics PHYSICAL EVALUATION

This medical history form should be retained by the healthcare provider and/or parent. This form is valid for 365 calendar days from the date of exam

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

Student's Full Name: _____ Biological Sex: _____ Age: _____
Date of Birth: ___ /___ /_____ School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____Phone: (_____) _____
Name of Parent/Guardian: _____E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Other Phone: (_____) _____ Family
Healthcare Provider: _____City/State: _____ Office Phone: (_____)_____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

_____

Have you ever been diagnosed with a concussion or head injury? Yes / No

Have you ever experienced chest pain, fainting, or shortness of breath during exercise? Yes / No

Do you wear corrective lenses or contacts? Yes / No

Do you currently have any injuries or conditions limiting participation? Yes / No

If yes, please explain _____

Have you ever passed out or nearly passed out during or after exercise? Yes / No

Do you have any ongoing medical issues or recent illnesses? Yes / No

If yes, please explain _____

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

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creigfreeman@semschools.com

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Participation in school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year. 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 physical evaluation required by Florida Statute 1006.20, 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 (ECG), echocardiogram (ECHO), and/or cardio stress test. Ahfachkee Athletics strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed)

Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed)

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

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PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /____ School: _____

Height: _____Weight: _____ BP: ____/____ (____ /____) Pulse: _____ Vision: R 20/___ L 20/____

Corrected: Yes / No

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
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 Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		

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MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Elbow and Forearm		
Wrist, Hand, Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof.

Name of Healthcare Professional (print or type): _____

Date of Exam: ___ / ___ / _____ Address: _____ Phone: (____) _____ E-mail: _____

Signature of Healthcare Professional: _____

Credentials: _____ License #: _____

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MEDICAL ELIGIBILITY FORM

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent.

☐ Check this box if there is no relevant medical history to share related to participating in competitive sports.

Provider Stamp Here_____ (if required by school)

Medications: (use additional sheet, if necessary) List:

_____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: (explain below, use additional sheet, if necessary)

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other Explain:

_____

_____

Signature of Student: _____ Date: ___/___/___

Signature of Parent/Guardian:_____ Date: ___/___/___

We hereby state, to the best of our knowledge, the information recorded on this form is complete and correct. 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 (ECG), echocardiogram (ECHO), and/or cardio stress test.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction after clearance by medical specialist for:_____ (If this option is checked, additional medical follow-up and clearance prior to sports participation is required.)

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports Recommendations:

_____

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I hereby certify that I am a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with my regulatory board, or a practitioner who holds an active equivalent licensure issued by the state in which the medical evaluation was performed and that I, or a clinician under my direct supervision, have examined the abovenamed student-athlete using the Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____

Date of Exam: ___ / ___ / _____

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____

License #: _____

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