



**PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)**  
*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.*

**EL2**

**Revised 2/26**

**MEDICAL HISTORY FORM**

**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: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work 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):

**Patient Health Questionnaire version 4 (PHQ-4)**

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

|                                             | Not at all | Several days | Over half of the days | Nearly everyday |
|---------------------------------------------|------------|--------------|-----------------------|-----------------|
| Feeling nervous, anxious, or on edge        | 0          | 1            | 2                     | 3               |
| Not being able to stop or control worrying  | 0          | 1            | 2                     | 3               |
| Little interest or pleasure in doing things | 0          | 1            | 2                     | 3               |
| Feeling down, depressed, or hopeless        | 0          | 1            | 2                     | 3               |

| GENERAL QUESTIONS                                                                                |                                                                                                    | Yes | No | HEART HEALTH QUESTIONS ABOUT YOU         |                                                                                                                                                                                                                                                                                                                   | Yes | No |
|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----|----|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Explain "Yes" answers at the end of this form.<br>Circle questions if you don't know the answer. |                                                                                                    |     |    | (continued)                              |                                                                                                                                                                                                                                                                                                                   |     |    |
| 1                                                                                                | Do you have any concerns that you would like to discuss with your provider?                        |     |    | 8                                        | Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?                                                                                                                                                                                             |     |    |
| 2                                                                                                | Has a provider ever denied or restricted your participation in sports for any reason?              |     |    | 9                                        | Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                              |     |    |
| 3                                                                                                | Do you have any ongoing medical issues or recent illnesses?                                        |     |    | 10                                       | Have you ever had a seizure?                                                                                                                                                                                                                                                                                      |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU                                                                 |                                                                                                    | Yes | No | HEART HEALTH QUESTIONS ABOUT YOUR FAMILY |                                                                                                                                                                                                                                                                                                                   | Yes | No |
| 4                                                                                                | Have you ever passed out or nearly passed out during or after exercise?                            |     |    | 11                                       | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)                                                                                                                                            |     |    |
| 5                                                                                                | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?          |     |    | 12                                       | Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? |     |    |
| 6                                                                                                | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? |     |    | 13                                       | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?                                                                                                                                                                                                                            |     |    |
| 7                                                                                                | Has a doctor ever told you that you have any heart problems?                                       |     |    |                                          |                                                                                                                                                                                                                                                                                                                   |     |    |

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



## PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

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**EL2**

**Revised 2/26**

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_

| BONE AND JOINT QUESTIONS |                                                                                                            | Yes | No |
|--------------------------|------------------------------------------------------------------------------------------------------------|-----|----|
| 14                       | Have you ever had a stress fracture?                                                                       |     |    |
| 15                       | Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? |     |    |
| 16                       | Do you have a bone, muscle, ligament, or joint injury that currently bothers you?                          |     |    |

| MEDICAL QUESTIONS |                                                                                                                                                   | Yes | No |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 17                | Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?                     |     |    |
| 18                | Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?                                                                    |     |    |
| 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? |     |    |
| 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?                                                                           |     |    |

| MEDICAL QUESTIONS (continued) |                                                                                  | Yes | No |
|-------------------------------|----------------------------------------------------------------------------------|-----|----|
| 26                            | Do you worry about your weight?                                                  |     |    |
| 27                            | Are you trying to or has anyone recommended that you gain or lose weight?        |     |    |
| 28                            | Are you on a special diet or do you avoid certain types of foods or food groups? |     |    |
| 29                            | Have you ever had an eating disorder?                                            |     |    |

Explain "Yes" answers here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Participation in high 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, and FHSAA Bylaw 9.7, 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. The FHSAA Sports Medicine Advisory Committee 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.*  
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**EL2**

Revised 2/26

**PHYSICAL EXAMINATION FORM**

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_

**HEALTHCARE PROFESSIONAL REMINDERS:**

Consider additional questions on more sensitive issues.

|                                                                                                    |                                                                                                                         |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| • Do you feel stressed out or under a lot of pressure?                                             | • Do you ever feel sad, hopeless, depressed, or anxious?                                                                |
| • Do you feel safe at your home or residence?                                                      | • During the past 30 days, did you use chewing tobacco, snuff, or dip?                                                  |
| • Do you drink alcohol or use any other drugs?                                                     | • Have you ever taken anabolic steroids or used any other performance-enhancing supplement?                             |
| • Have you ever taken any supplements to help you gain or lose weight or improve your performance? | • Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year? |

- ☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment.  
Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

**EXAMINATION**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**BP:** \_\_\_\_ / \_\_\_\_ ( \_\_\_\_ / \_\_\_\_ ) **Pulse:** \_\_\_\_\_ **Vision:** R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ **Corrected:** Yes No

**MEDICAL - healthcare professional shall initial each assessment** **NORMAL** **ABNORMAL FINDINGS**

|                                                                                                                                                                                   |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) |  |  |
| Eyes, Ears, Nose, and Throat<br>• Pupils equal<br>• Hearing                                                                                                                       |  |  |
| Lymph Nodes                                                                                                                                                                       |  |  |
| Heart<br>• Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)                                                                                            |  |  |
| Lungs                                                                                                                                                                             |  |  |
| Abdomen                                                                                                                                                                           |  |  |
| Skin<br>• 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                                                                             |  |  |
| Elbow and Forearm                                                                            |  |  |
| Wrist, Hand, and Fingers                                                                     |  |  |
| Hip and Thigh                                                                                |  |  |
| Knee                                                                                         |  |  |
| Leg and Ankle                                                                                |  |  |
| Foot and Toes                                                                                |  |  |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test |  |  |

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

\*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Healthcare Professional: \_\_\_\_\_ Credentials: \_\_\_\_\_ License #: \_\_\_\_\_



## PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date of exam.

**EL2**

Revised 2/26

### MEDICAL ELIGIBILITY FORM

**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: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_  
Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

#### 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 participation in competitive sports.

Provider Stamp (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. Use Form EL1/2S for documentation.)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

In accordance with §1006.20(2)(c), F.S., 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 above-named student-athlete using the FHSAA EL2 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 #: \_\_\_\_\_

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