

**Bay District Schools  
Athletic Physical Examination Form**  
This form is good for one calendar year from the date of the Physician signature

**PART 1. STUDENT INFORMATION**

Student Name \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
 School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ School Sport(s): \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Parent's Home Phone: (\_\_\_\_) \_\_\_\_\_ Parent's Work Phone: (\_\_\_\_) \_\_\_\_\_ Parent's Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Personal/Family Physician: \_\_\_\_\_ City/State \_\_\_\_\_ Physician's Office Phone: (\_\_\_\_) \_\_\_\_\_

**PART 2. MEDICAL HISTORY** Circle Y for YES and N for NO for the following questions:

1. Have you had a medical illness or injury since your last check up or sports physical? Y N
2. Do you have an ongoing chronic illness? Y N
3. Have you been hospitalized overnight? Y N
4. Have you ever had surgery? Y N
5. Are you currently taking any prescription or non-prescription (over the counter medications), pills or using an inhaler? Y N
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Y N
7. Do you have allergies (pollen, medicine, food, or stinging insects)? Y N
8. Have you ever had a rash or hives develop during or after exercise? Y N
9. Have you ever passed out during/after exercise? Y N
10. Have you ever been dizzy during/after exercise? Y N
11. Have you ever had chest pains during/after exercise? Y N
12. Do you get tired more quickly than your friends during exercise? Y N
13. Have you ever had racing or skipping of your heartbeats? Y N
14. Have you had high blood pressure/cholesterol? Y N
15. Have you been told you have a heart murmur? Y N
16. Has any family members/relative died of heart problems or sudden death before age 50? Y N
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Y N
18. Has a physician ever denied or restricted your participation in sports for any heart problems? Y N
19. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)? Y N
20. Have you ever had a head injury or concussion? Y N
21. Have you ever been knocked out, become unconscious or lost your memory? Y N
22. Have you ever had a seizure? Y N
23. Do you have frequent or severe headaches? Y N
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Y N
25. Have you ever had a stinger, burner, or pinched nerve? Y N
26. Have you ever become ill from exercising in the heat? Y N
27. Do you cough, wheeze or have trouble breathing during or after activity? Y N

28. Do you have asthma? Y N
  29. Do you have seasonal allergies that require medical treatment? Y N
  30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or a hearing aid)? Y N
  31. Do you have any problems with your eyes or vision? Y N
  32. Do you wear glasses, contacts, or protective eyewear? Y N
  33. Have you ever had a sprain, strain, or swelling after injury? Y N
  34. Have you broken or fractured any bones or dislocated any joints? Y N
  35. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? Y N
- If yes, mark appropriate ones and explain below\*\*.
- |              |             |              |
|--------------|-------------|--------------|
| ___Head      | ___Neck     | ___Back      |
| ___Chest     | ___Shoulder | ___Upper Arm |
| ___Elbow     | ___Forearm  | ___Wrist     |
| ___Hand      | ___Finger   | ___Foot      |
| ___Hip       | ___Thigh    | ___Knee      |
| ___Shin/Calf | ___Ankle    |              |
36. Do you want to weigh more or less than you do now? Y N
  37. Do you lose weight regularly to meet weight requirements for your sport? Y N
  38. Do you feel stressed out? Y N
  39. Record the dates of your most recent immunizations (shots) for:  
 Tetanus: \_\_\_\_\_ Measles: \_\_\_\_\_  
 Hepatitis B: \_\_\_\_\_ Chickenpox \_\_\_\_\_
- \*\*Explain Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Females Only** (Optional)

40. When was your first menstrual period? (year) \_\_\_\_\_
41. When was your most recent menstrual period? \_\_\_\_\_
42. How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
43. How many periods have you had in the last year? \_\_\_\_\_
44. What was the longest time between periods in the last year? \_\_\_\_\_

We hereby state, that, to the best of my 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.

By signing this document, I attest that I do not have insurance coverage or Medicaid for my minor child indicated on this document. Also, by signing this document as parent/legal guardian, I consent for the physical examination to be performed on my child and acknowledge receipt of the Department of Health Notice of Privacy Rights.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

EMS.0400.211A/BayCHD2010

**NOTARIZED SIGNATURE REQUIRED IF PARENT NOT ATTENDING**

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 2010 by

\_\_\_\_\_ parent/legal guardian of minor \_\_\_\_\_.

**STATE OF FLORIDA  
COUNTY OF BAY**

**PART 3. PHYSICAL EXAMINATION** (to be completed by physician)

Student/s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_ % Blood Sugar (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Visual Acuity: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL FINDINGS	NORMAL	ABNORMAL FINDINGS	*INITIALS
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
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/NURSE PRACTITIONER**

I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_\_ Cleared without limitation.  
\_\_\_\_\_ Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_\_\_ Referred to: \_\_\_\_\_ For \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician/Nurse Practitioner (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Signature of Physician/Nurse Practitioner: \_\_\_\_\_

**ASSESSMENT OF REFERRED PHYSICIAN (IF APPLICABLE)**

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

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

Recommendations: \_\_\_\_\_

Name of Referred Physician (print or type): \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_