EL2

Revised 06/19

Seminole County Public Schools, Florida

Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.
This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.

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: _____ 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: (____)_____

Schools Attended: 8th _____ 9th _____ 10th _____ 11th _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

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

36.	Do you want to weigh more or less than you do now?	____	____
37.	Do you lose weight regularly to meet weight requirements for your sport?	____	____
38.	Do you feel stressed out?	____	____
39.	Have you ever been diagnosed with sickle cell anemia?	____	____
40.	Have you ever been diagnosed with having the sickle cell trait?	____	____

41. Record the dates of your most recent immunizations (shots) for:
Tetanus: _____ Measles: _____
Hepatitus 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 in 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, 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 (EKG), echocardiogram (ECG) and/or cardio stress test.

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

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Preparticipation Physical Evaluation (Page 2 of 3)

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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: ____/____ (____/____, ____/____)

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 PRACTITIONER

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 Date of Exam ____/____/_____

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/_____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

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Preparticipation Physical Evaluation (Page 3 of 3)

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Student's Name: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself 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): _____ 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.

Seminole County Public Schools, Florida

Sports Screening/Physical & Parent/Student Release Form

Addendum to SCPS Form 985

I.
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.

II.
I further hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I understand that this authorization is voluntary and that I may revoke it at any time by submitting the revocation in writing to my school.

III.
I hereby grant to FHSAA the right to review all records relevant to my athletic eligibility including, but not limited to, my records relating to enrollment and attendance, academic standing, age, discipline, finances, residence and physical fitness.

IV.
I understand that the authorizations and rights are voluntary and that I may revoke them at any time by submitting said revocation in writing to my school. By doing so, however, I understand that I will no longer be eligible for participation in interscholastic athletics.

I/We Parent(s) and Student Athlete have read this information carefully and know it contains a release.
<u>This form must be signed in the presence of a notary.</u>

PRINT NAME CLEARLY

Student _____ Student Signature _____

Date _____

Parent _____ Parent Signature _____

Date _____

State of Florida

County of _____ Sworn to and subscribed before me this _____ day of _____ 20___

( ) is personally known or produced identification ( ) type of identification produced _____

Notary Stamp

_____

Signature of Notary Public

SCPS Form 985a (Rev.06/01/08) FL Distribution: White Copy: Trainer Yellow Copy: Principal–designee Pink Copy: Parent/Student

SCHOOL _____ Grade_____

SEMINOLE COUNTY PUBLIC SCHOOLS, FI – ATHLETICS EMERGENCY CARD 20__-20__

ATHLETE _____ MALE ☐ FEMALE ☐ BIRTHDATE _____
Last Name First Name (MM/DD/YY)

DATE OF PHYSICAL _____ Insurance ( ) Birth Certificate ( ) GPA _____ Eligible ( )

PHYSICIAN'S NAME _____ **PHONE** _____

ALLERGIES _____ EYE GLASSES: YES ☐ NO ☐ CONTACTS: ☐YES ☐ NO

MEDICATIONS _____ **EMERGENCY MEDICATIONS:**_____

MEDICAL CONCERNS:_____

MOTHER'S NAME _____ Cell Phone _____ Home Phone _____

FATHER'S NAME _____ Cell Phone _____ Home Phone_____

HOME ADDRESS_____
(Number & Street) (Apt. #) (City) (Zip Code)

PERSON AUTHORIZED TO CARE FOR STUDENT IN CASE PARENT CANNOT BE REACHED:

NAME _____ ADDRESS _____

PHONE _____ CELL PHONE _____ RELATIONSHIP _____

Your insurance must remain current during this sport. You must notify your coach immediately if you change residence, cell phone number or no longer have insurance coverage.

SCPS Form 1416 (Rev. 2/22/16) SB **** COMPLETE BOTH SIDES OF THIS FORM ****

PARENTAL CONSENT

STUDENT'S FULL NAME_____ AGE _____

SCHOOL _____**GRADE** _____

I consent to the sharing of my child's health information as listed on the reverse side with appropriate school personnel unless specified in writing to the principal.

In the event of serious accident of illness, I request that the school contact me. If I cannot be reached, the school may make the necessary arrangements to provide emergency care and treatment for my child. This may include conveyance to and treatment at a hospital of medical facility. I will assume responsibility of payment for services rendered.

In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request the school contact me or my spouse to arrange transportation for my child. If the school is unable to contact a parent/legal guardian, I request that one of the persons listed on the reverse side of this form be contacted and requested to care for my child.

All medical concerns regarding my child have been provided on this card for the care of my child.

We have health insurance through _____
(NAME OF COMPANY) (POLICY #)

We have purchased Student Accident Insurance to supplement my personal insurance. ☐YES ☐ NO
https://schoolinsuranceofflorida.com/pages/parent_pages/9035

PARENT OR LEGAL GUARDIAN _____DATE_____
(SIGNATURE)

THE SCHOOL BOARD OF SEMINOLE COUNTY, FLORIDA
WAIVER AND RELEASE FOR ATHLETIC PARTICIPATION

I. Student Release and Waiver – to be signed by student

I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury and even death is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be otherwise emancipated, I hereby release and hold harmless the School Board of Seminole County, Florida, its officers, employees and agents; the school district of Seminole County, Florida; and my school (including but not limited to, the principal, athletic director, coaches, staff, and athletic trainers) of any and all responsibility and liability, including liability for their own negligence, for any injury or claim involving such athletic participation. This includes but is not limited to practice, fundraising, games, and competitions. I agree to take no legal action against any of the above listed parties involving my participation in athletic activities.

I have read this waiver carefully and know it contains a release

Student name (printed)	Student Signature	Date

II. Parental Release and Waiver – to be completed by parent/guardian or adult student with legal authority to make educational decisions

I know of and acknowledge that my child/ward is participating in interscholastic activities and such participation includes risks, including serious injury and even death. I voluntarily accept any and all responsibility for my child's safety and welfare while participating in athletics and fully understand the risks involved. On behalf of myself and my child, I hereby release and hold harmless the School Board of Seminole County, Florida, its officers, employees and agents; the school district of Seminole County, Florida; and my child's school (including but not limited to, the principal, athletic director, coaches, staff, and athletic trainers) of any and all responsibility and liability, including liability for their own negligence, for any injury or claim involving such athletic participation. This includes but is not limited to practice, fundraising, games, and competitions. I agree to take no legal action on behalf of myself or my child against any of the above listed parties involving my child's participation in athletic activities.

I have read this waiver carefully and know it contains a release

Parent/Guardian name (printed) (or adult student)	Parent/Guardian signature (or adult student)	Date