

**PRE-PARTICIPATION ATHLETIC  
 SCREENING FORM**

School: \_\_\_\_\_ School Year: 20\_\_-20\_\_

**Part 1. Student Information** (to be completed by student or parent).

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security #: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_  
 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.

- |  | Yes | No  |   | Yes               | No            |
|--|-----|-----|---|-------------------|---------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?                                     | ___ | ___ | 27. Do you cough, wheeze, or have trouble breathing during or after activity?   | ___               | ___           |
| 2. Do you have an ongoing chronic illness?   | ___ | ___ | 28. Do you have asthma?   | ___               | ___           |
| 3. Have you ever been hospitalized overnight?  | ___ | ___ | 29. Do you have seasonal allergies that require medical treatment?  | ___               | ___           |
| 4. Have you ever had surgery?  | ___ | ___ | 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, hearing aid)? | ___               | ___           |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 31. Have you had any problems with your eyes or vision?   | ___               | ___           |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?              | ___ | ___ | 32. Do you wear glasses, contacts, or protective eyewear?   | ___               | ___           |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                  | ___ | ___ | 33. Have you ever had a sprain, strain, or swelling after injury?   | ___               | ___           |
| 8. Have you ever had a rash or hives develop during or after exercise?   | ___ | ___ | 34. Have you broken or fractured any bones or dislocated any joints?  | ___               | ___           |
| 9. Have you ever passed out during or after exercise?  | ___ | ___ | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?  | ___               | ___           |
| 10. Have you ever been dizzy during or after exercise?   | ___ | ___ | <i>If yes, check appropriate blank and explain below.</i>   |                   |               |
| 11. Have you ever had chest pain during or after exercise?   | ___ | ___ | ___ Head  | ___ Elbow         | ___ Hip       |
| 12. Do you get tired more quickly than your friends do during exercise?  | ___ | ___ | ___ Neck  | ___ Forearm       | ___ Thigh     |
| 13. Have you ever had racing of your heart or skipped heartbeats?  | ___ | ___ | ___ Back  | ___ Wrist         | ___ Knee      |
| 14. Have you had high blood pressure or high cholesterol?  | ___ | ___ | ___ Chest   | ___ Hand          | ___ Shin/Calf |
| 15. Have you ever been told you have a heart murmur?   | ___ | ___ | ___ Shoulder  | ___ Finger        | ___ Ankle     |
| 16. Has any family member or relative died of heart problems or sudden death before age 50?                                  | ___ | ___ | ___ Upper Arm   | ___ Foot          |               |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                 | ___ | ___ | 36. Do you want to weigh more or less than you do now?  | ___               | ___           |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems?                           | ___ | ___ | 37. Do you lose weight regularly to meet weight requirements for your sport?  | ___               | ___           |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                  | ___ | ___ | 38. Do you feel stressed out?   | ___               | ___           |
| 20. Have you ever had a head injury or concussion?   | ___ | ___ | 39. Record the dates of your most recent immunizations (shots) for:   |                   |               |
| 21. Have you ever been knocked out, become unconscious, or lost your memory?   | ___ | ___ | Tetanus: _____  | Measles: _____    |               |
| 22. Have you ever had a seizure?   | ___ | ___ | Hepatitis B: _____  | Chickenpox: _____ |               |
| 23. Do you have frequent or severe headaches?  | ___ | ___ | 40. Have you ever been diagnosed with measles?  | ___               | ___           |
| 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?   | ___ | ___ | 41. Have you ever been diagnosed with mumps?  | ___               | ___           |
| 25. Have you ever had a stinger, burner, or pinched nerve?   | ___ | ___ | <b>FEMALES ONLY (optional)</b>  |                   |               |
| 26. Have you ever become ill from exercising in the heat?  | ___ | ___ | 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 FHSA 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.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**THE SCHOOL DISTRICT OF ESCAMBIA COUNTY  
PRE-PARTICIPATION ATHLETIC SCREENING**

20\_\_\_\_-20\_\_\_\_

ECHO Needed:

Yes  No

**Part 3. Physical Examination (to be completed by physician).**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_/\_\_\_\_)  
 Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
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/Ann	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____
ECHOCARDIOGRAM (Optional)	_____	_____	_____

Year student-athlete received Echo: \_\_\_\_\_

\* - station-based examination only

**ASSESSMENT OF EXAMINING PHYSICIAN**

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.  
 \_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_ Referred to: \_\_\_\_\_ For: \_\_\_\_\_

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

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

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

Signature of Physician: \_\_\_\_\_, MD or DO

**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.  
 \_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

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

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

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

Signature of Physician: \_\_\_\_\_, MD or DO

*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.*