



Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on fle 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)

| 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 ests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test. |
| Signature of Student: Date:// Signature of Parent/Guardian: Date:// |
| -1 <i>-</i> |
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Revised 03/16



Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 2 of 3)

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| Height Weight Seady Fat (optional): Pulse: Blood Pressure: (, / | Student's Name: | | | | | | | |
|--|---------------------------|-----------------------------|-------------------|-----------------|-----------|-----------------|------------------------|----------|
| Visual Acadys: Right 20/ Left 20/ Corrected: Yes No Pupils Equal Unequal | | | | | 1 4150. | Blood I lessure | | _, |
| MEDICAL 1. Appearance 2. Eyes Earl/Nose/Throat 3. Lymph Nodes 4. Heart 5. Pubes 6. Lungs 7. Abdomen 8. Genitalia (males only) 9. Skin MUSCULOSKELETAL 10. Neck 11. Back 12. Shoulder/Arm 13. Eibow/Forearm 14. Wrist/Hand 15. Hip/Thigh 16. Knee 17. Leg/Ankle 18. Foot | | | | | Equal | Unequal | | |
| I. Appearance 2. Eyes/Ears/Nose/Throat 3. Lymph Nodes 4. Heart 5. Pubes 6. Lungs 7. Abdomen 8. Genitalia (males only) 9. Skin MUSCULOSKELETAL 10. Neck 11. Back 12. Shoulder/Arm 13. Elbow/Forearm 14. Wisto/Hand 15. Hip/Thigh 16. Knee 17. Leg/Ankle 18. Foot 4. They/Ankle 18. Foot 5. They/Ankle 18. Foot 6. Shoulder in the following conclusion(s): Cleared without limitation Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to Reason: Cleared after completing evaluation/rehabilitation for: Referred to Por: Referred to For: Recommendations: | FINDINGS | NORMAL | | ABNO | RMAL FIND | INGS | | INITIALS |
| 2. Eyes-Tars/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 18. Foot 19. Station-based examination only ASSESMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER Iberby 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to Pro: Referr | MEDICAL | | | | | | | |
| 3. I Jymph 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 Thereby 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 Disability: Diagnosis: Precautions: Not cleared for: Resommendations: | 1. Appearance | | | | | | | |
| 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 *- station-based examination only *- Station-based examination isted above was 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: Referred to For: Referred to For: | 2. Eyes/Ears/Nose/ | Throat | | | | | | |
| 5. Pulses 6. Langs 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 ** astion-based examination only ** astion-based examination only ** assistant/Nurse practitions* Cleared without limitation Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | 3. Lymph Nodes | | | | | | | |
| 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 It 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Referre | 4. Heart | | | | | | | |
| 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 **SESSMENT 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | 5. Pulses | | | | | | | |
| 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 *- station-based examination listed above was 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: Referred to For: Recommendations: | 6. Lungs | | | | | | | |
| 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 *- station-based examination only *- Station-based examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s): Cleared without limitation Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Referred to For: | 7. Abdomen | | | | | | | |
| 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: | 8. Genitalia (males | only) | | | | | | |
| 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 *- station-based examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s): Cleared without limitation Disability: Diagnosis: Precautions: Not cleared for: Referred to For: Referred to For: Recommendations: | 9. Skin | | | | | | | |
| 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 II 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 Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: | MUSCULOSKELETAL | | | | | | | |
| 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 Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Referred to For: | 10. Neck | | | | | | | |
| 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: | 11. Back | | | | | | | |
| 14. Wrist/Hand 15. Hip/Thigh 16. Knee 17. Leg/Ankle 18. Foot *- station-based examination only *- Station-based examination listed above was 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: Referred to For: Referred to For: | 12. Shoulder/Arm | | | | | | | |
| 15. Hip/Thigh 16. Knee 17. Leg/Ankle 18. Foot *- station-based examination only *- Station-based examination only *- Station-based examination listed above was 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: Referred to For: Recommendations: | 13. Elbow/Forearm | | | | | | | |
| 16. Knee | 14. Wrist/Hand | | | | | | | |
| 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 _ Disability: Diagnosis: Precautions: Reason: | 15. Hip/Thigh | | | | | | | |
| 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 Disability: Diagnosis: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | 16. Knee | | | | | | | |
| * – 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 Disability: Diagnosis: Precautions: Reason: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: For: | 17. Leg/Ankle | | | | | | | |
| 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 Disability: Diagnosis: Precautions: Reason: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: For: | 18. Foot | | | | | | | |
| 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 Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | * – station-based examina | ation only | | | | | | |
| 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 Disability: Precautions: Not cleared for: Reason: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | A SSESSMENT OF FY | MINING PHYSICIAN | /PHVSICIAN ASSIST | 'A NT/NI IRSE I | PRACTITIO | NFP | | |
| Cleared without limitation Disability: Precautions: Not cleared for: Cleared after completing evaluation/rehabilitation for: Referred to For: Recommendations: | | | | | | | e following conclusion | on(s): |
| Disability: | • • | | | | • | • | | . , |
| Precautions: | | | | Diagno | osis: | | | |
| Not cleared for: | | | | <i>U</i> | | | | |
| Not cleared for: | Precautions: | | | | | | | |
| Cleared after completing evaluation/rehabilitation for: | | | | | | | | |
| Cleared after completing evaluation/rehabilitation for: Referred to | Not cleared for: | | | | | Reason: | | |
| Referred toFor: | | | | | | | | |
| Recommendations: | Cleared after compl | eting evaluation/rehabilita | ation for: | | | | | |
| Recommendations: | | | | | | | | |
| Recommendations: | | | | | | | | |
| | | | | | | | | |
| Name of Physician/Physician Assistant/Nurse Practitioner (print): | | | | | | | | |
| · · · · · · · · · · · · · · · · · · · | Name of Physician/Physic | cian Assistant/Nurse Prac | titioner (print): | | | | Date: | / |
| Address: | | | | | | | | |
| | Signature of Physician/Ph | nysician Assistant/Nurse F | ractitioner | | | | | |





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Preparticipation Physical Evaluation (Page 3 of 3)

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| ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applica | able) | | |
|--|----------------------------------|-----------------------------|------------------------------------|
| I hereby certify that the examination(s) for which referred was/were perfo | ormed by myself or an individual | under my direct supervisior | n with the following conclusion(s) |
| Cleared without limitation | | | |
| Disability: | | | |
| Precautions: | | | |
| Not cleared for: | | | |
| Cleared after completing evaluation/rehabilitation for: | | | |
| Recommendations: | | | |
| Name of Physician (print): | | | |
| Address: | | | |
| | | | |
| Signature of Physician: | | | |