



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 2/25

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 (continued)		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.							
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?						

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PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)
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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:

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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)
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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 Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat - Pupils equal - Hearing		
Lymph Nodes		
Heart Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin 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 Double-leg squat test, single-leg squat test, and box drop or step drop test		

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*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 2/25

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 EL2 Page 5 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 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 #: _____

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



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)
SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL
This form is valid for 365 calendar days from the date of exam.

EL2

Revised 2/25

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider 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: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- ☐ Medically eligible for all sports without restriction as of the date signed below
☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

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

Name of Healthcare Professional (print or type): _____ Date of Exam: ____/____/____

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*



Seminole County Public Schools –Electrocardiogram (ECG) Screening Form

An ECG screening (also referred to as an EKG) can help identify young adults who are at-risk for sudden cardiac death that results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. In accordance with Seminole County School Board Policy 2431, The School Board of Seminole County, Florida requires that each student athlete planning to participate in high school athletics receive an Electrocardiogram (ECG) screening as part of the High School Pre-Participation Physical prior to participating in the physical activity. An ECG screening clearance only needs to be obtained one-time while in high school. An ECG screening can be completed and evaluated by Who We Play For, Inc., the SCPS approved vendor, or may also be performed and evaluated by a Licensed Physician, PA or ARNP of your choice.

RELEASE AND WAIVER

In consideration of the named student athlete being able to participate in the activities listed above, I/we do hereby release and hold harmless the School Board of Seminole County, and its officers, employees and assigns against any and all responsibility or liability of any nature for any injury or claim resulting from the pre-participation ECG screening, and agree to take no legal action against the School Board of Seminole County, or its officers, employees or agents for claims arising out of, resulting from or involving the pre-participation ECG screening.

☐ If your normal ECG was completed by Who We Play For, Orlando Health, Advent Health, or Nemours, you can STOP here. Submit the Normal ECG documentation from the organization to the Athletic Clearance Profile. You do not need to submit this form.

Student Name: (print): _____ School Name: _____

Sex: (circle) M / F DOB: _____ Age: _____ Grade: _____ Student ID#: _____

ECG's Performed by a PCP, Urgent Care Center, or Walk-in Clinic Must Complete the Form Below

PHYSICIAN INSTRUCTIONS: This form is to be completed by an appropriate health care provider (AHCP) trained in the latest ECG interpretation guidelines. It is recommended to interpret ECG readings based on the International Criteria (<https://uwsportscardiology.org/>) After completing and interpreting the ECG, select the appropriate box below. If the ECG is interpreted as NORMAL, complete the Normal Electrocardiogram Screening section. If the initial ECG is interpreted as ABNORMAL, the student must be referred to a cardiologist. Only a cardiologist can determine if a student with an ABNORMAL ECG is eligible for all sports without restriction.

NORMAL Electrocardiogram (ECG) Screening (To be completed by a Licensed Physician, PA or ARNP)

I hereby certify that an ECG was performed by myself or an individual under my direct supervision and have determined that the patient is eligible for all sports without restriction.

Name of Licensed Physician, PA or ARNP (Print) Signature of Licensed Physician, PA or ARNP Date

Address: _____ City: _____ Zip: _____ Phone: _____

Stamp of Physician Office:

☐ An ABNORMAL ECG was found, and the student has been referred to a cardiologist. Physician Name: _____ Date: _____

ABNORMAL Electrocardiogram (ECG) Screening (To be completed by a Cardiologist or Pediatric Cardiologist)

I hereby certify that an ECG was found, and the student was subsequently evaluated by a cardiologist or pediatric cardiologist. I hereby certify that the student above has had a cardiac evaluation and is eligible for all sports without restriction.

Name of Licensed Physician, PA or ARNP (Print) Signature of Licensed Physician, PA or ARNP Date

Address: _____ City: _____ Zip: _____ Phone: _____

Stamp of Cardiologist/Pediatric Cardiologist Office:

Student/Parent/Legal Guardian Name (Print) **

Student/Parent/Legal Guardian (Signature) **

Student/Parent/Legal Guardian Phone #

Date

**If student athlete is under eighteen (18) years of age, parent/guardian must complete and sign this form.

Once completed, please upload this document into your Athletic Clearance Profile.