Elementary Schools in the Diocese of St. Petersburg

Pre-participation Physical Evaluation

St. Stephen Catholic School

DATE____________________

Form must be completed in its entirety. No other documentation should be attached.
Completed form must be filed in the school office.

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

Student's Name:____________________ **Gender**__ **Age:**___ **Date of Birth:**__________
School:____________________ **Grade:**___ **Sport(s):**____________________
Home Address:______________________________ **Home Phone:**____________________
City/ State/Zip code______________________________ **Work Phone:**____________________
Name of Parent/Guardian: ______________________________ **Other**____________________
Person to Contact in Case of Emergency:____________________**Phone**________ **Other**________ **Relationship to student:**__________
Personal / Family Physician______________________________ **Office Phone:**____________________

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

	Yes	No
1.Has the student had a medical illness or injury since the last check up or sports physical?		
2.Does the student have an ongoing chronic illness?		
3.Has the student ever been hospitalized overnight?		
4.Has the student ever had surgery?		
5.Is the student currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?		
6 Has the student ever taken any supplements or vitamins to aid in gaining or losing weight or improving performance ?		
7.Does the student have any allergies (ie, pollen, medicine, food, or insect stings)?		
8.Has the student ever had a rash or hives develop during or after exercise?		
9.Has the student ever passed out during or after exercise?		
10.Has the student ever been dizzy during or after exercise?		
11.Has the student ever had chest pain during or after exercise?		
12.Does the student get tired more quickly than others during exercise?		
13.Has the student ever had a racing heart/ skipped heartbeats?		
14. Has the student had high blood pressure/ high cholesterol?		
15. Has the student ever been told he/she has a heart murmur?		
16. Has any family member or relative died of heart problems or sudden death before age 50?		
17. Has the student had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
18. Has a physician ever denied or restricted participation in sports for any heart problems?		
19. Does the student have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?		
20. Has the student ever had a head injury or concussion?		
21. Has the student ever been knocked out, become unconscious, or lost his/her memory?		
22. Has the student ever had a seizure?		
23. Does the student have frequent or severe headaches?		
24. Has the student ever had numbness or tingling in arms, hands, legs, or feet?		
25. Has the student ever had a stinger, burner, or pinched nerve?		

	Yes	No
26. Has the student ever become ill from exercising in the heat?		
27. Does the student cough, wheeze, or have trouble breathing during or after activity?		
28. Does the student have asthma?		
29.Has the student have seasonal allergies that require medical treatment?		
30.Does the student use any special protective or corrective equipment or devices that aren't usually used for sports (for example, knee brace, special neck roll, tooth retainer, hearing aid?		
31. Has the student had any problems with his/her eyes or vision?		
32. Does the student wear glasses, contacts, or protective eyewear?		
33Has the student ever had a sprain, strain, or swelling after injury?		
34. Has the student broken or fractured any bones or dislocated any joints?		
35. Has the student had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate blank and explain below		

shoulder	____	finger	____	head	____
upper arm	____	foot	____	neck	____
elbow	____	thigh	____	back	____
forearm	____	knee	____	chest	____
wrist	____	shin/calf	____	hip	____
hand	____	ankle	____		

36. Date of most recent tetanus shot:

Explain any "yes" responses here:

#__ ____________________________

#__ ____________________________

#__ ____________________________

#__ ____________________________

#__ ____________________________

Additional Notations:

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 evaluations required by the State of Florida and the Elementary Schools in the Diocese of St. Petersburg, we understand and acknowledge that it is suggested that the student should undergo formal assessments of the heart, which may include such diagnostic tests as catherization, electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Parent/Guardian____________________
Date____________________

For School Office: Date received:_______ Administrator signature____________________

St. Stephen Catholic School

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

Student's Name______________________________ Date of Birth______________
Height:________ Weight:______________ Pulse: ______________ Blood Pressure:______________
Visual Acuity: Right 20/____ Left 20/____ Corrected: 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. Menstrual Cycle			
10. Skin			
11. Musculoskeletal			
12. Neck			
13. Back			
14. Shoulder/Arm			
15. Elbow/Forearm			
16. Wrist/Hand			
17. Hip/Thigh			
18. Knee			
19. Leg/Ankle			
20. Foot			

* - 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 conclusions:

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 indivual 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

NB: This form was 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 and the FHSAA