PINELLAS COUNTY SCHOOLS

PCSB Marching Band Preparticipation Physical Evaluation

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 pages 1 and 2 of this form to be re-submitted.

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

Student Name:______________________ Sex: ________ Age: ______ Date of Birth: ______/______/________

School: ____ Grade in School: __________

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 (______)____________

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

	YES	NO		YES	NO
1. Have you had a medical illness or injury since your last check up or physical?			26. Have you ever become ill from exercising in the heat?		
2. Do you have an ongoing chronic illness?			27. Do you cough, wheeze or have trouble breathing during or after activity?		
3. Have you ever been hospitalized overnight?			28. Do you have asthma?		
4. Have you ever had surgery?			29. Do you have seasonal allergies that require medical treatment?		
5. Are you currently taking any prescription or non-prescription (over-the-counter medications or pills or using an inhaler?			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)?		
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or Improve your performance?			31. Have you had any problems with your eyes or vision?		
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?			32. Do you wear glasses, contacts or protective eye wear?		
8. Have you ever had a rash or hives develop during or after exercise?			33. Have you ever had a sprain, strain or swelling after injury?		
9. Have you ever passed out during or after exercise?			34. Have you broken or fractured any bones or dislocated any joints?		
10. Have you ever been dizzy during or after exercise?			35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
11. Have you ever had chest pain during or after exercise?			If yes, check appropriate blank and explain below:		
12. Do you get tired more quickly than your friends do during exercise?			Head ______ Elbow ______ Hip ______		
13. Have you ever had racing of your heat or skipped heartbeats?			Neck ______ Forearm ______ Thigh ______ Back ______ Wrist ______ Knee ______		
14. Have you had high blood pressure or high cholesterol?			Chest ______ Hand ______ Shin/Calf ______ Finger ______ Ankle ______ Foot ______		
15. Have you ever been told you have a heart murmur?			Upper Arm/Shoulder ______		

16. Has any family member or relative died of heart problems or sudden death before age 50?			36. Do you want to weigh more than you do now?		
17. Have you had a severe viral infection (for example. myocarditis or mononucleosis) within the last month?			37. Do you lose weight regularly to meet weight requirements for your sport?		
18. Has a physician ever denied or restricted your participation in sports for any heart problems?			38. Do you feel stressed out?		
19. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, blisters or pressure sores)?			39. Have you ever been diagnosed with sickle cell anemia?		
20. Have you ever had a head injury or concussion?			40. Have you ever been diagnosed with having the sickle cell trait?		
21. Have you ever been knocked out, become unconscious or lost your memory?			41. Record the dates of your most recent immunizations (shots) for: Tetanus: ____________ Measles: ____________ Hepatitis B: ____________ Chickenpox: ____________		
22. Have you ever had a seizure?			FEMALES ONLY (optional)		
23. Do you have frequent or severe headaches?			When was your first menstrual period? ____________ Most recent? __________ How much time do you usually have from the start of one period to the start of another? __________		
24. Have you ever had numbness or tingling in your arms, hands legs or feet?			How many periods have you had in the last year? ______		
25. Have you ever had a stinger, burner or pinched nerve?			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 question s are 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 (EKG). Echocardiogram (ECG) and/or cardio stress test.

Signature of Student: ______________________________ Date: ______/______/______

Signature of Parent/Guardian: ______________________________ Date: ______/______/______

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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).

Students 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, Pulse s			
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

______ 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: ______________________ Date: ____/____/______

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Student 's Name: ______________________________

Assessment of Physician to Whom Referred (if applicable)

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: ______________________________

____

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

Address: ______________________________

Signature of Physician/Physician Assistant/Nurse Practitioner: ______________ Date: ____/____/____