

**THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA**

**Martin County School District Pre-Participation Physical Evaluation For Middle Schools Only**

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.

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

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 School: \_\_\_\_\_ 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.**

- |  |  |               |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
|--|--|---------------|-----------|---------|----------|-------------|-----------|----------|-----------|----------|-----------|----------|---------------|-----------|------------|--------------|----------|---------------|--|
| <p align="center"><b>Yes No</b></p> <p>1. Have you had a medical illness or injury since your last check up or sports physical?</p> <p>2. Do you have an ongoing chronic illness?</p> <p>3. Have you ever been hospitalized overnight?</p> <p>4. Have you ever had surgery?</p> <p>5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?</p> <p>6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</p> <p>7. Do you have any allergies (i.e. to pollen, medicine, food, latex or stinging insects)?</p> <p>8. Have you ever had a rash or hives develop during or after exercise?</p> <p>9. Have you ever passed out during or after exercise?</p> <p>10. Have you ever been dizzy during or after exercise?</p> <p>11. Have you ever had chest pain during or after exercise?</p> <p>12. Do you get tired more quickly than your friends do during exercise?</p> <p>13. Have you ever had racing of your heart or skipped heartbeats?</p> <p>14. Have you had high blood pressure or high cholesterol?</p> <p>15. Have you ever been told you have a heart murmur?</p> <p>16. Has any family member or relative died of heart problems or sudden death before age 50?</p> <p>17. Have you had a severe viral infection (i.e. myocarditis, or mononucleosis) within the last month?</p> <p>18. Has a physician ever denied or restricted your participation in sports for any heart problems?</p> <p>19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters or pressure sores)?</p> <p>20. Have you ever had a head injury or concussion?</p> <p>21. Have you ever been knocked out, become unconscious, or lost your memory?</p> <p>22. Have you ever had a seizure?</p> <p>23. Do you have frequent or severe headaches?</p> <p>24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?</p> <p>25. Have you ever had a stinger, burner, or pinched nerve?</p> | <p align="center"><b>Yes No</b></p> <p>26. Have you ever become ill from exercising in the heat?</p> <p>27. Do you cough, wheeze, or have trouble breathing during or after activity?</p> <p>28. Do you have asthma?</p> <p>29. Do you have seasonal allergies that require medical treatment?</p> <p>30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e., knee brace, special neck roll, foot orthotics,shunt, retainer on your teeth, hearing aid)?</p> <p>31. Have you had any problems with your eyes or vision?</p> <p>32. Do you wear glasses, contacts or protective eyewear?</p> <p>33. Have you ever had a sprain, strain or swelling after injury?</p> <p>34. Have you broken or fractured any bones or dislocated any joints?</p> <p>35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?</p> <p><i>If yes, check appropriate blank and explain below:</i></p> <table border="0" style="width:100%"> <tr> <td>___ Head</td> <td>___ Elbow</td> <td>___ Hip</td> </tr> <tr> <td>___ Neck</td> <td>___ Forearm</td> <td>___ Thigh</td> </tr> <tr> <td>___ Back</td> <td>___ Wrist</td> <td>___ Knee</td> </tr> <tr> <td>___ Chest</td> <td>___ Hand</td> <td>___ Shin/Calf</td> </tr> <tr> <td>___ Ankle</td> <td>___ Finger</td> <td>___ Shoulder</td> </tr> <tr> <td>___ Foot</td> <td>___ Upper Arm</td> <td></td> </tr> </table> <p>36. Do you want to weigh more or less than you do now?</p> <p>37. Do you lose weight regularly to meet weight requirement for your sport?</p> <p>38. Do you feel stressed out?</p> <p>39. Have you ever been diagnosed with Sickle Cell Anemia?</p> <p>40. Have you ever been diagnosed with having sickle cell trait?</p> <p>41. Record the dates of your most recent immunizations for:<br/>         Tetanus: _____ Measles _____ Hepatitis B _____ Chickenpox _____</p> <p><b>FEMALES ONLY (Optional)</b></p> <p>42. When was your first menstrual period? _____</p> <p>43. When was your most recent menstrual period? _____</p> <p>44. How much time do you usually have from the start of one period to the start of another? _____</p> <p>45. How many periods have you had in the last year? _____</p> <p>46. What was the longest time between periods in the last year? _____</p> | ___ Head      | ___ Elbow | ___ Hip | ___ Neck | ___ Forearm | ___ Thigh | ___ Back | ___ Wrist | ___ Knee | ___ Chest | ___ Hand | ___ Shin/Calf | ___ Ankle | ___ Finger | ___ Shoulder | ___ Foot | ___ Upper Arm |  |
| ___ Head   | ___ Elbow  | ___ Hip       |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
| ___ Neck   | ___ Forearm  | ___ Thigh     |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
| ___ Back   | ___ Wrist  | ___ Knee      |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
| ___ Chest  | ___ Hand   | ___ Shin/Calf |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
| ___ Ankle  | ___ Finger   | ___ Shoulder  |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |
| ___ Foot   | ___ Upper Arm  |               |           |         |          |             |           |          |           |          |           |          |               |           |            |              |          |               |  |

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, 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: \_\_\_\_\_