FLORIDA INDEPENDENT CHRISTIAN ATHLETIC ASSOCIATION
MEDICAL HISTORY/PHYSICAL EXAMINATION FORM

(PAGE 1 OF 2)

STUDENT INFORMATION **TODAY'S DATE:** _____

Student Full Name: _____

Date of Birth: ____/____/____ **Sex:** _____ **Age:** _____ **Grade:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone Number: (____) ____-____ **Parent/Guardian Email Address:** _____

Name of Parent(s)/Guardian(s): _____

Person to Contact in Case of Emergency: _____ **Relationship to Student:** _____

Home Phone: (____) ____-____ **Work Phone:** (____) ____-____ **Cell Phone:** (____) ____-____

Sport(s): _____

ANSWER ALL QUESTIONS BELOW. EXPLAIN "YES" ANSWERS BELOW:	YES	NO
1. Has a doctor ever restricted/denied your participation in sports?		
2. Have you ever been hospitalized or spent a night in a hospital?		
3. Do you have any ongoing medical conditions (i.e. diabetes, asthma, etc.)		
4. Are you presently taking any medications or pills (prescription or over-the-counter)?		
5. Do you have any allergies?		
6. Have you ever been dizzy or passed out during or after exercise?		
7. Have you ever had chest pain or discomfort in your chest during or after exercise?		
8. Do you tire more quickly than your friends during exercise?		
9. Have you ever been diagnosed with high blood pressure, a heart murmur, high cholesterol, or a heart infection?		
10. Have you ever had racing of your heart or skipped heartbeats?		
11. Has anyone in your family died of heart problems or had a sudden death prior to age 50?		
12. Does anyone in your family have a heart condition?		
13. Has a doctor ever ordered a test on your heart (EKG, echocardiogram, etc.)?		
14. Do you have any current skin problems (itching, rashes, staph infection, MRSA, acne, etc.)?		
15. Have you ever had a head injury or concussion?		
16. Have you ever been knocked out, become unconscious, or lost your memory?		
17. Have you ever had a seizure?		
18. Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
19. Have you ever had heat or muscle cramps?		
20. Have you ever been dizzy or passed out in the heat?		
21. Do you have trouble breathing or do you cough during or after activity?		
22. Do you take any medication for asthma?		
23. Do you use any special protective or corrective equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?		
24. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?		
25. Have you had any other medical problems, diagnoses, or difficulties? Have you had a medical problem or injury since your last evaluation		
26. Have you had a medical problem or injury since your last evaluation?		
27. Have you or a family member ever been diagnosed with the sickle cell trait or sickle cell anemia?		
28. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones, muscles, tendons, or joints? ( ) Head/Neck ( ) Back ( ) Hip ( ) Chest ( ) Shoulder/Elbow/Arm ( ) Foot/Ankle ( ) Knee ( ) Finger/Hand/Wrist ( ) Leg/Thigh/Shin		
29. Do you feel stressed out?		

FEMALES ONLY

30. When was your first menstrual period? _____ When was your last menstrual period? _____

31. What was the longest time between your periods last year? _____

32. RECORD THE DATES ON YOUR MOST RECENT IMMUNIZATION (SHOTS) FOR:

Tetanus: _____ Measles: _____ Hepatitus B: _____ Chicken Pox: _____

Explain All "Yes" Answers Here:

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct.

Signature of Student: _____ Date: ____/____/_____ Signature of Parent/Guardian: _____ Date: ____/____/_____

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MEDICAL HISTORY/PHYSICAL EXAMINATION FORM
(PAGE 2 OF 2)

For any student to be eligible for interscholastic athletics, there must be a current Medical History Form on file in your school's office (signed by a physician) certifying that the student has passed a physical exam, and that in the opinion of the examining physician the student is fully able to participate in interscholastic athletics. A physical exam will satisfy the requirement for 365 calendar days from the date of the exam, as written on this page. 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.

PHYSICAL EXAMINATION **TODAY'S DATE:** _____

Student Full Name: _____ **Date of Birth:** ____ / ____ / ____

Height _____ **Weight:** _____ **Pulse:** _____ **Blood Pressure:** _____

Temperature: _____ **Hearing** **Right:** _____ **Left:** _____

Vision: **R 20/** _____ **L 20/** _____ **Corrected (Choose One):** **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			
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			

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: _____ **Phone:** _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____