OCPS 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 page 1 of this form to be re-submitted.

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

Students 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:** Head _____ Elbow _____ Hip _____ Neck _____ Forearm _____ Thigh _____ Back _____ Wrist _____ Knee _____ Chest _____ Hand _____ Shin/Calf _____ Finger _____ Ankle _____ Foot _____ Upper Arm Shoulder_____		
12. Do you get tired more quickly than your friends do during exercise?					
13. Have you ever had racing of your heat or skipped heartbeats?					
14. Have you had high blood pressure or high cholesterol?					
15. Have you ever been told you have a heart murmur?					
16. Has any family member or relative died of heart problems or sudden death before age 50?			36. Do you want to weigh more or less 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 s port?		
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)** 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? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____		
23. Do you have frequent or severe headaches?					
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?					
25. Have you ever had a stinger, burner or pinched nerve?					

Explain "YES" answers here: _____

_____

We hereby state, to the best of our knowledge, that our answers to the above questions 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. Pulses			
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: _____/_____/_____