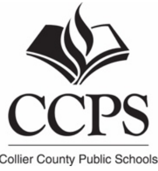

CCPS High School Marching Band Participant Physical Evaluation Form

Part 1. Student Information

Student's Name: ______________________________ Sex: ____ Age: ____ Date of Birth: _____/_____/_____

School: ______________________________ Grade in School: ____ Student School ID#: ______________________

Home Address: ______________________________ Home Phone: (_____) _______________

Name of Parent/Guardian: ______________________________ Parent/Guardian E-mail: ______________________________

Person to Contact in Case of Emergency: ______________________________ Relationship: ______________________________

Home Phone: (______) ___________________ Work Phone: (______) __________________ Cell Phone: (_______) ___________________

Personal/Family Physician: ______________________________ City/State: ____________________ Phone: (______) ________________

Part 2. Medical History *(to be completed by parent/guardian or student. "YES" answers should be explained below.)*

		Yes	No
1.	Have you been diagnosed with a new medical condition since your last check up or physical?	____	____
2.	Do you have an ongoing chronic illness or medical condition?	____	____
3.	Have you ever had surgery?	____	____
4.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or using an inhaler?	____	____
5.	Do you have any allergies (for example, pollen, latex, medicine, food, or stinging insects?	____	____
6.	Do you have seasonal allergies that require medical treatment or restrictions?	____	____
7.	Have you ever had a rash or hives develop during or after exercise?	____	____
8.	Have you ever passed out during or after exercise?	____	____
9.	Have you ever become dizzy during or after exercise?	____	____
10.	Have you ever had racing of your heart or skipped heartbeats?	____	____
11.	Have you ever been told you have a heart murmur?	____	____
12.	Has a physician ever denied or restricted your activity levels for any reason?	____	____
13.	Have you ever had a head injury or concussion?	____	____
14.	Have you ever had numbness or tingling in your arms, hands, legs or feet?	____	____
15.	Have you ever become ill from exercising in the heat?	____	____
16.	Do you use any special protective or corrective equipment or medical devices (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth, or hearing aid?	____	____
17.	Have you had any problems with your eyes or vision?	____	____
18.	Do you wear glasses, contacts, or protective eyewear?	____	____
19.	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check appropriate blank and explain below:	____	____

___ Head	___ Elbow	___ Hip	___ Neck	___ Forearm	___ Thigh	___ Back
___ Wrist	___ Knee	___ Chest	___ Hand	___ Shin/Calf	___ Shoulder	___ Finger
___ Ankle	___ Foot	___ Upper Arm				

Explain "Yes" answers here: ____

If this student is required to take medication during afterschool activities, please complete attached Collier County Public Schools Medication Authorization Form and return to Activities Director.

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, and FHSAA Bylaw 9.7, 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 Parent/Guardian: ______________________________________ Date: ____/____/____

Part 3. Physical Examination *(to be completed by licensed physician, physician assistant or certified advanced registered nurse practitioner).*

Student's 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	INTIALS*	FINDINGS	NORMAL	ABNORMAL FINDINGS	INTIALS*
MEDICAL				MUSCULOSKELETAL			
1. Appearance	________	______________	________	9. Neck	________	______________	________
2. Eyes/Ears/Nose/Throat	________	______________	________	10. Back	________	______________	________
3. Lymph Nodes	________	______________	________	11. Shoulder/Arm	________	______________	________
4. Heart	________	______________	________	12. Elbow/Forearm	________	______________	________
5. Pulses	________	______________	________	13. Wrist/Hand	________	______________	________
6. Lungs	________	______________	________	14. Hip/Thigh	________	______________	________
7. Abdomen	________	______________	________	15. Knee	________	______________	________
8. Skin	________	______________	________	16. Leg/Ankle	________	______________	________
				17. 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: ____

Signature of Physician/Physician Assistant/Nurse Practitioner:____

ASSESSMENT OF EXAMINING PHYSICIAN TO WHOM REFERRED *(if applicable)*

I hereby certify that each examination for which referred was/were 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:____

Place Healthcare Provider Stamp Here: