Due June 5, 2023

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: