

DUVAL COUNTY SCHOOLS PREPARTICIPATION ATHLETIC SCREENING FORM • SIDE I

Name: _____ Sex: F M Age: _____ Date of Birth _____ / _____ / _____
 Grade: _____ School: _____ Sport(s): _____
 Address: _____
 Personal Physician: _____ Physicians Phone: _____
 In case of emergency: Name: _____ Relationship: _____ Phone: _____

For Physician use only
(Circle One)
 New Interval 1 Interval 2
 Date: _____

**SIDE I OF THIS FORM MUST BE COMPLETELY FILLED OUT AND SIGNED BY BOTH THE ATHLETE AND THE PARENT/GUARDIAN
 CIRCLE QUESTIONS THAT YOU DO NOT KNOW THE ANSWERS TO**

Yes	No	◀ CHECK ONE EXPLAIN YES ANSWERS ON THE BACK
1		Have you had a medical illness or injury since your last check up or sports physical?
2		Do you have any ongoing or chronic diseases?
3		Have you ever been hospitalized overnight?
4		Have you ever had surgery?
5		Are you currently using prescription or non prescription (over the counter) medications, pills or inhalers?
6		Have you ever taken supplements or vitamins to help you gain or loose weight or improve your performance?
7		Do you have allergies? (foods, insects or medications)
8		Have you ever had a rash or hives develop during or after exercise? Have you ever.....
9		passed out during or after exercise?
10		been dizzy during or after exercise?
11		had chest pain during or after exercise?
12		Do you tire more quickly than your friends during exercise? Have you ever had?.....
13		Racing of your heart or skipped heartbeats?
14		High blood pressure/ high cholesterol?
15		been told you have a heart murmur?
16		any family member or relative die of a heart attack or sudden death before age 50?
17		Are there any children in your family with heart problems?
18		Have any children in your family passed out or had a seizure as a result of a heart problem?
19		Have you had a severe viral infection(myocarditis or mononucleosis)?
20		Has a physician ever denied or restricted your participation in sports for any heart problems?
21		Do you have current skin problems (itching, rashes, acne, warts, fungus or blisters) Have you ever had
22		a head injury or concussion?
23		been knocked out, become unconscious, or lost your memory?
24		a seizure?
25		numbness or tingling in your arms, hands, legs or feet?

Yes	No	◀ CHECK ONE EXPLAIN YES ANSWERS ON THE BACK
26		a stinger, burner, or pinched nerve?
27		frequent or severe headaches?
28		Have you ever become ill from exercising in the heat?
29		Do you cough, wheeze or have trouble breathing during or after activity?
30		Do you have asthma?
31		Do you have seasonal allergies that require medical treatment?
32		Do you use any special protective or correctional equipment or devices that aren't usually used for your sport or position?(knee braces, neck roll, foot orthotics, retainer (teeth) hearing aid)
33		Have you had any problems with your eyes or vision?
34		Do you wear glasses, contacts or protective eyewear?
35		Have you ever had a sprain, strain, or swelling after injury?
36		Have you broken or fractured any bones or dislocated any joints?
37		Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? See Checklist on Side II
38		Do you want to weigh more or less than you do now?
39		Do you lose weight regularly to meet requirements of your sport?
40		Do you feel stressed?
Record the dates of your most recent immunizations: Tetanus _____ Measles _____ Hepatitis B _____ Chicken Pox _____		
Females Only		
41		When was your first menstrual period? Age _____ or Date _____ Not yet: <input type="checkbox"/>
42		When was you most recent period? Started: _____
43		How much time do you usually have from the start of one period to the start of another? _____
44		How many periods have you had in the past year?
45		What was the longest time between periods in the last year?
46		Do you have questions or concerns regarding your menstrual cycle?
47		Do you have any questions or concerns you wish to ask the doctor?

SIGN I HEREBY STATE, THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

▶ **ATHLETE SIGNATURE** _____ **PARENT SIGNATURE:** _____

PARENT OR GUARDIAN READ AND SIGN: I certify that the information above is true and I consider him/her capable of participating in athletics. I hereby give my consent for the above named student: (1) to represent his/her school in athletic activities, except for those exceptions cited by the examining physician, provided that such athletic activities are approved by the School Board /FHSAA.(2) to accompany the team of which he/she is a member on any of its local or out of town trips. I further authorize the school to obtain any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel and understand the cost of such treatment will be at my expense. I also agree not to hold the School Board or anyone acting in its behalf or the FHSAA responsible for any injury occurring to the above named student in the course of such athletic activities or such travel. I also grant permission to the Duval County School Board to release any and all athletic injury information relating to the above named student to the Sports Medicine Program Injury Registry. The Preparticipation Athletic Screening performed today is limited and designed to identify common conditions or infirmities that would limit or prevent a student from participating in athletic activities. This examination is NOT intended to be comprehensive and may not detect some types of latent or hidden medical conditions. ALL athletes should receive routine comprehensive medical examinations and prompt treatment for illnesses and injuries.

I DO _____ I DO NOT _____ Wish to purchase the school Student Accident or Football Insurance.

SIGN I have read and understand the above statements.

▶ **Signature of Parent / Guardian:** _____ **Date:** _____ / _____ / _____

Any YES answers should be explained on Side II

Explain YES Answers Here

Question 37: Head Neck Shoulder Arm Elbow Wrist Hand Finger Back Chest Hip Thigh Knee Shin/Calf Ankle Foot
 Please Describe:

Duval County Schools Preparticipation Screening Form • Side II

Physical Examination:

Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ %Body Fat _____ Pulse _____ BP: ____/____
 (____/____)

Vision: R 20/____ L 20/____ Corrected: Y N Contacts / Glasses _____ Pupils: Equal Unequal Other: _____

	Normal	Abnormal	Initials
Medical			
Appearance			
EENT			
Lymph Nodes			
Heart			
Appearance			
Pulses			
Lungs			
Abdomen			
Genitals			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Neurological			

Clearance

Cleared JSMP 1325 San Marco Blvd; suite 301 Jacksonville, FL 32207 • 904-202-5219 Date: ____/____/____

Physicians Name: _____
 Printed Signature

Not Cleared for: Sport(s): _____

Reason: _____

Recommendation: _____

Physicians Name: _____
 Printed Signature

Physician / Follow up

Diagnosis: _____ DATE: _____

May Participate with NO restrictions May Participate, but with restrictions May NOT participate

Limitations: _____

Physicians Name: _____
 Printed Signature

Address: _____ Phone: _____

2008-2009