



SPORTS PHYSICAL INTAKE FORM

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Social Security Number		Date of Birth		U.S. Military Service (<input checked="" type="checkbox"/> one): <input type="checkbox"/> None <input type="checkbox"/> Currently Serving <input type="checkbox"/> Discharged
Address		City		State
		Zip Code		County
Home Phone ()		Work Phone ()		Cell Phone ()
Email				
Marital Status (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		Primary Language Spoken: <input type="checkbox"/> Limited English		Patient's Relationship to Responsible Party (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent
Gender (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Female <input type="checkbox"/> Male				
Race (<input checked="" type="checkbox"/> one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one Race <input type="checkbox"/> Choose Not To Disclose				
Ethnicity (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Choose Not To Disclose				
Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your annual income? <input type="checkbox"/> \$1-\$27,000 <input type="checkbox"/> \$27,001-\$33,000 <input type="checkbox"/> \$33,001-\$40,000 <input type="checkbox"/> \$40,001+ <input type="checkbox"/> No Income				
How many people (including you) does your income support? _____				
Which describes your housing situation? <input type="checkbox"/> Own/Rent <input type="checkbox"/> Public Housing <input type="checkbox"/> Homeless				
Emergency Contact			Phone ()	
			Relationship to Patient	
RESPONSIBLE PARTY INFORMATION (enter name of person FINANCIALLY responsible for your account)				
Last Name		First Name		Middle Initial
Mailing Address		City		State
		Zip Code		County
Home Phone ()		Work Phone ()		Cell Phone ()
		Date of Birth		Social Security Number
INSURANCE COMPANY – INCLUDING MEDICAID				
Primary Insurance		ID#		Group #
		Insurance Company Address		
Name of Insured		Date of Birth		Insured's Employer
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				
Assignment and Release: <i>I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.</i>				
PARENT/GUARDIAN SIGNATURE: _____				DATE: _____

Consent for Treatment

I hereby authorize PanCare Health, its facilities and treatment centers, its affiliated providers, dentists, dental hygienists, nurse practitioners, physician assistants, psychologists, social workers and other medical personnel to administer examinations and treatments as deemed medically necessary.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____



Preparticipation Physical Evaluation (Page 1 of 3)

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 student or parent)

Student's Name: Sex: Age: Date of Birth: School:
Grade in School: Sport(s):
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 student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
2. Do you have an ongoing chronic illness? Yes No
3. Have you ever been hospitalized overnight? Yes No
4. Have you ever had surgery? Yes No
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? Yes No
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes No
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? Yes No
8. Have you ever had a rash or hives develop during or after exercise? Yes No
9. Have you ever passed out during or after exercise? Yes No
10. Have you ever been dizzy during or after exercise? Yes No
11. Have you ever had chest pain during or after exercise? Yes No
12. Do you get tired more quickly than your friends do during exercise? Yes No
13. Have you ever had racing of your heart or skipped heartbeats? Yes No
14. Have you had high blood pressure or high cholesterol? Yes No
15. Have you ever been told you have a heart murmur? Yes No
16. Has any family member or relative died of heart problems or sudden death before age 50? Yes No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Yes No
18. Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? Yes No
20. Have you ever had a head injury or concussion? Yes No
21. Have you ever been knocked out, become unconscious or lost your memory? Yes No
22. Have you ever had a seizure? Yes No
23. Do you have frequent or severe headaches? Yes No
24. Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes No
25. Have you ever had a stinger, burner or pinched nerve? Yes No
26. Have you ever become ill from exercising in the heat? Yes No
27. Do you cough, wheeze or have trouble breathing during or after activity? Yes No
28. Do you have asthma? Yes No
29. Do you have seasonal allergies that require medical treatment? Yes No
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)? Yes No
31. Have you had any problems with your eyes or vision? Yes No
32. Do you wear glasses, contacts or protective eyewear? Yes No
33. Have you ever had a sprain, strain or swelling after injury? Yes No
34. Have you broken or fractured any bones or dislocated any joints? Yes No
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Yes No
If yes, check appropriate blank and explain below:
Head Elbow Hip
Neck Forearm Thigh
Back Wrist Knee
Chest Hand Shin/Calf
Shoulder Finger Ankle
Upper Arm Foot
36. Do you want to weigh more or less than you do now? Yes No
37. Do you lose weight regularly to meet weight requirements for your sport? Yes No
38. Do you feel stressed out? Yes No
39. Have you ever been diagnosed with sickle cell anemia? Yes No
40. Have you ever been diagnosed with having the sickle cell trait? Yes No
41. Record the dates of your most recent immunizations (shots) for:
Tetanus: Measles:
Hepatitis B: Chickenpox:
FEMALES ONLY (optional)
42. When was your first menstrual period?
43. When was your most recent menstrual period?
44. How much time do you usually have from the start of one period to the start of another?
45. How many periods have you had in the last year?
46. What was the longest time between periods in the last year?

Explain "Yes" answers here:

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