A Pre-Participation Examination (PPE) is required by Florida Statute 1002.20(17)(b), 1006.20(2)(c) and FHSAA Bylaw 9.7 to ensure safe participation in sports by student-athletes.

Specifically: Submission of the full EL2 to member schools. This request is to adopt the updated FHSAA EL2 form (four total pages) recommended by the SMAC with the exception of removing questions 30-33. Furthermore, only the fourth page of the EL2 (the medical eligibility form) will be submitted to the member school. The qualified health care practitioner performing the examination or parent/guardian will keep the medical history and/or examination forms (pages 1-3).

The submission of the full FHSAA EL2 Form to member schools has created concerns and questions from parents, school district administrators, school board members, and coaches regarding the health privacy of student-athletes. While the Association understands it is vital to protect the privacy of all student-athletes, we must address the important role medical history plays in a pre-participation physical examination. Therefore, this recommendation provides pertinent medical history to the qualified health care practitioner and gives schools the medical authorization necessary for allowing athletic participation, while protecting the privacy of the student-athlete.

The Executive Director endorses adopting the updated EL2 form (as amended above in the topic section) and requiring only the fourth page (Medical Eligibility) to be collected by the member school. Pages 1-3 of the EL2 will remain with the qualified health care practitioner performing the examination or parent/guardian of the student-athlete.

The intent of this proposal is to provide an updated PPE form which protects a student-athlete’s privacy while including pertinent medical information a health care provider at a member school would need access to.

Printed Name of Individual/Committee Submitting Item
Craig Damon

Printed Name of FHSAA Staff Member Presenting Item

Signature
PAGES TO BE KEPT BY
QUALIFIED HEALTH CARE PRACTITIONER
OR
PARENT/GUARDIAN
This medical history form should be retained by the healthcare provider and/or parent. This form is valid for 365 calendar days from the date signed below.

**HISTORY FORM**

**Student Information (to be completed by student and parent)**

Student's full name: __________________________ Sex assigned at birth: _______ Age: _______ Date of birth: _______ / _______ / _______

School: __________________________ Grade in school: _______ Sport(s): _______

Home address: __________________________ City: ___________ Home phone: (____) _______ _______ _______

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

Person to contact in case of emergency: __________________________ Relationship to student: _______

Emergency contact cell phone: (____) _______ Work phone: (____) _______ Other phone: (____) _______

Family healthcare provider: __________________________ City/State: __________________________ Office phone: (____) _______ _______ _______

List past and current medical conditions:

__________________________________________________________

Have you ever had surgery? If yes, please list all surgical procedures and dates: __________________________

Medicines and supplements: Please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional) __________________________

Do you have any allergies? If yes, please list all of your allergies (ie. medicines, pollens, food, insects) __________________________

---

**Patient Health Questionnaire version 4 (PHQ-4)**

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

<table>
<thead>
<tr>
<th>Feeling nervous, anxious or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half of the days</th>
<th>Nearly everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not being able to stop or control worrying</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half of the days</th>
<th>Nearly everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Little interest or pleasure in doing things</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half of the days</th>
<th>Nearly everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling down, depressed or hopeless</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half of the days</th>
<th>Nearly everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

---

**General Questions**

Explain "yes" answers at the end of this form. Circle questions if you don't know the answer.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Has a provider ever denied or restricted your participation in sports for any reason?</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Do you have any ongoing medical issues or recent illnesses?</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

---

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

Yes | No
---|---

| 4   | Have you ever passed out or nearly passed out during or after exercise? | 11  | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash) |
| 5   | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | 12  | Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, and/or other congenital heart defect? |
| 6   | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | 13  | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? |
| 7   | Has a doctor ever told you that you have any heart problems? | 14  | |

This form is not considered valid unless all sections are complete.
**PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)**

This medical history form should be retained by the healthcare provider and/or parent. This form is valid for 365 calendar days from the date signed below.

<table>
<thead>
<tr>
<th>Student-athlete name:</th>
<th>Date of birth:</th>
<th>School:</th>
</tr>
</thead>
</table>

**BONE AND JOINT QUESTIONS**

| 14 | Have you ever had a stress fracture? | Yes | No |
| 15 | Did you ever injure a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game? | Yes | No |
| 16 | Do you have a bone, muscle ligament, or joint injury that currently bothers you? | Yes | No |

**MEDICAL QUESTIONS (continued)**

| 26 | Do you worry about your weight? |
| 27 | Are you trying to or has anyone recommended that you gain or lose weight? |
| 28 | Are you on a special diet or do you avoid certain types of foods or food groups? |
| 29 | Have you ever had an eating disorder? |

**MEDICAL QUESTIONS**

| 17 | Do you cough, wheeze or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma? |
| 18 | Are you missing a kidney, an eye, a testicle, your spleen or any other organ? |
| 19 | Do you have groin or testicle pain or a painful bulge or hernia in the groin area? |
| 20 | Do you have any recurring skin rash or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)? |
| 21 | Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? |
| 22 | Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? |
| 23 | Have you ever become ill while exercising in the heat? |
| 24 | Do you or does someone in your family have sickle cell trait or disease? |
| 25 | Have you ever had or do you have any problems with your eyes or vision? |

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute §1006.20, requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation evaluation as the first step of injury prevention. This preparticipation medical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

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 §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 (ECG), echocardiogram (ECHO) and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your health care provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student: Athlete Name: ___________________________ (Printed) Student Athlete Signature: ___________________________ Date: __/__/____

Parents/Guardian Name: ___________________________ (Printed) Parent/Guardian Signature: ___________________________ Date: __/__/____

Physical Examination Form:

Student-athlete name: ___________________________ Date of birth ______/_____/_______ School: ____________

PHYSICIAN REMINDERS
Consider additional questions on more-sensitive issues:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel stressed out or under a lot of pressure?</td>
<td>Do you ever feel sad, hopeless, depressed, or anxious?</td>
</tr>
<tr>
<td>Do you feel safe at your home or residence?</td>
<td>During the past 30 days, did you use chewing tobacco, snuff, or dip?</td>
</tr>
<tr>
<td>Do you drink alcohol or use any other drugs?</td>
<td>Have you ever taken anabolic steroids or used any other performance-</td>
</tr>
<tr>
<td>Have you ever taken any supplements to help you gain or lose weight</td>
<td>enhancing supplement?</td>
</tr>
<tr>
<td>or improve your performance?</td>
<td></td>
</tr>
</tbody>
</table>

☐ Verify completion of FHSAA EL2 Medical History form pages 1 and 2, review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include (Q4-Q13 of History Form). (check box, if complete)

EXAMINATION
Height: ___________________________ Weight: ___________________________
BP: ______/_____/_______ Pulse: ______/_____/_______ Vision: R 20/____ L 20/____ Corrected: ☐ Y ☐ N

MEDICAL – healthcare professional shall initial each assessment

**NORMAL**  **ABNORMAL FINDINGS**

**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral
  valve prolapse [MVP], and aortic insufficiency)

**Eyes, ears, nose, and throat**
- Pupil equal
- Hearing

**Lymph nodes**

**Heart**
- Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

**Lungs**

**Abdomen**

**Skin**
- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

**Neurological**

MUSCULOSKELETAL – healthcare professional shall initial each assessment

**NORMAL**  **ABNORMAL FINDINGS**

**Neck**

**Back**

**Shoulder and arm**

**Elbow and forearm**

**Wrist, hand, and fingers**

**Hip and thigh**

**Knee**

**Leg and ankle**

**Foot and toes**

**Functional**
- Double-leg squat test, single-leg squat test, and box drop or step drop test

This form is not considered valid unless all sections are complete.

* Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee (SMAC) strongly recommends to a student athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of healthcare professional (print or type): ___________________________ Date of exam: ______/_____/_______

Address: ___________________________ Phone: ___________________________ Email: ___________________________

Signature of healthcare professional: ___________________________ Credentials: ___________________________

License #: ___________________________

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This completed form shall be kept on file by the school. This form is valid for 365 calendar days from the dated signature below.

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student or parent)

Student's name: ___________________________ Sex assigned at Birth: ________ Age: ________ Date of birth: ________ / ________ / ________

School: ___________________________ Grade in school: ________ Sport(s): ________

Home address: ___________________________ City: ________ Home phone: (______) ________

Name of Parent/Guardian: ___________________________ E-mail: ___________

Person to contact in case of emergency: ___________________________ Relationship to student: ________

Emergency contact cell phone: (______) Work phone: (______) Other phone: (______) ________

Family healthcare provider: ___________________________ City/State: ________ Office phone: (______) ________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: (use additional sheet, if necessary)

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports

Recommendations: (use additional sheet, if necessary)

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed and treated by an appropriate health care professional prior to participation in activities.

Name of healthcare professional (print or type): ___________________________ Date: ________ / ________ / ________

Address: ___________________________ Phone: ________

Signature of healthcare professional: ___________________________ Credentials: ________ License #: ________

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Medications: (use additional sheet, if necessary)

List: ___________________________

Relevant medical history to be reviewed by athletic trainer/team physician: explain below, odd additional sheets if necessary

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical history ☐ Sickle cell trait ☐ Other

Explain: ___________________________

Signature of student: ___________________________ Date: ________ / ________ / ________

Signature of Parent/Guardian: ___________________________ Date: ________ / ________ / ________

We hereby state, to the best of our knowledge, the information recorded on this form is 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 (ECG), echocardiogram (ECHO) and/or cardio stress test.

This form is not considered valid unless all sections are complete

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student or parent)

Student’s full name: ___________________________ Sex assigned at birth: _______ Age: _______ Date of birth: _______ / _______ / _______

School: ______________________________________ Grade in school: _______ Sport(s): __________________________

Home address: _____________________________ City: ___________________________ Home phone: (_____) ______________________

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

Person to contact in case of emergency: ___________________________ Relationship to student: ___________________________

Emergency contact cell phone: (_____) __________ Work phone: (_____) __________ Other phone: (_____) __________

Family healthcare provider: ___________________________ City/State: ___________________________ Office phone: (_____) ______________________

Referred for: ____________________________________ Diagnosis: ___________________________

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: (use additional sheet, if necessary)

☐ Medically eligible for only certain sports as listed below:

☐ Not medically eligible for any sports participation

Further Recommendations: (use additional sheet, if necessary)

Name of healthcare professional (print or type): ___________________________ Date: _______ / _______ / _______

Address: __________________________________________ Phone: (_____) ______________________

Signature of healthcare professional: ___________________________ Credentials: ___________________________ License #: ___________________________

Provider Stamp (if required by school)