

Physician's Report

Name of Participant: _____

PHYSICIAN'S REPORT – MUST BE COMPLETED BY PHYSICIAN IN ENGLISH

Based upon Florida statutes, any health professional who is licensed in Florida or the state/country the student resided in at the time of the health examination and who is authorized to perform a general health examination under such licensure shall be acceptable to complete the Physician's Report. A health professional includes an individual who is a licensed M.D., D.O., Physician's Assistant/P.A., or Nurse Practitioner/ ARNP.

RECENT ORTHOPEDIC HISTORY (required)

1. Has the student had any orthopedic injuries within the last six months? Yes No Date: _____
 a. If YES, please specify the injury: _____
 b. If YES, does the student have clearance to resume participation in sport in returning from the injury? Yes No

RECENT CONCUSSION HISTORY (required)

1. Has the student had a diagnosed concussion within the last six months? Yes No Date: _____
 a. If YES, does the student have clearance to resume participation in sport in returning from the injury? Yes No

PHYSICAL EXAM

Describe any variation from the norm N = Normal Ab = Abnormal

Teeth:	Scalp:	GI System:
Glands:	Extremities:	Vital Signs:
Lungs:	Eyes:	Menses:
Skin:	Ears:	Chest x-Ray:
Heart:	Abdomen:	Other:
Abnormal explained:		

SCREENING TESTS

Height: _____	Weight: _____	BP: _____	P: _____
Vision Distance Right _____ Left _____	With Correction	Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acuity: Right _____ Left _____	Without Correction	Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	

TUBERCULOSIS SCREENING (MANTOUX PPD SKIN TEST)

Have you been experiencing any of the following signs and symptoms that may be associated with tuberculosis?
 (Anyone with a "Yes" response will require a TB test or chest x-ray)

1 Persistent Cough (>3 weeks) <input type="checkbox"/> Yes <input type="checkbox"/> No	6 Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No
2 Coughing up Blood <input type="checkbox"/> Yes <input type="checkbox"/> No	7 Tire Easily <input type="checkbox"/> Yes <input type="checkbox"/> No
3 Unexplained Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	8 Have you ever had a positive TB skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No
4 Loss of Appetite <input type="checkbox"/> Yes <input type="checkbox"/> No	9 Have you ever taken prophylactic medication because you were exposed to TB? <input type="checkbox"/> Yes <input type="checkbox"/> No
5 Fever/Chills <input type="checkbox"/> Yes <input type="checkbox"/> No	

Date of Test:	Date Read:	2 nd Test Required: <input type="checkbox"/> Yes <input type="checkbox"/> No
Site:	Results in MM:	Date of 2 nd Test:
By:	By:	Site:
Manufacturer:		By:
Lot #:	Results in MM:	Expiration Date:

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12 POINT CARDIAC EVALUATION

Inspiration Academy is dedicated to the health and safety of our athletes. For that reason we have adopted the American Heart Association's 12 Point Recommendations for Pre-Participation Screening. **Any "yes" answers need to result in: (1) ECG (2) echocardiogram (3) letter of clearance from a cardiologist to be delivered prior to student's travel to Inspiration Academy.** Personal Medical History and Family Medical History sections may be completed by a parent/guardian.

PERSONAL MEDICAL HISTORY (Please see above for any "Yes" response)			COMMENTS
Exertional chest pain/discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Syncope/near syncope	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Excessive Exertional and otherwise unexplained dyspnea/fatigue associated with exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Prior recognition of heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Elevated blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FAMILY MEDICAL HISTORY (Please see above for any "Yes" response)			COMMENTS
Premature death (sudden or otherwise) related to heart disease in relatives younger than 50 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Disability from heart disease in close relative younger than 50 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Specific knowledge of hypertrophic or dilated cardiomyopathy, ion channelopathies such as long QT syndrome, Marfan Syndrome, or clinically important arrhythmias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

PHYSICAL EXAMINATION (Must be completed by a health professional – Please see above for any "Yes" response)			COMMENTS
Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Aortic Coarctation noted on Femoral Pulse Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Physical stigmata of Marfan syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Abnormal Brachial artery blood pressure (sitting position)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Notes: _____

THIS STUDENT IS CLEARED TO PARTICIPATE AS FOLLOWS:

Unrestricted Clearance

Specify limitations: _____

Additional information the examiner believes should be brought to the attention of Inspiration Academy to enable the student's wellbeing: _____

I understand that Inspiration Academy programs may include vigorous physical activities and exertion, which can occur in a hot and humid environment, such as Bradenton, Florida. I have discussed the "12 Point" cardiac evaluation with the student and parents, performed a physical examination and believe he/she is physically able to participate in athletic and sports activities as described.

Physician's Name (Print): _____

Physician's Signature: _____

Address: _____ Date: _____

City, State, Zip: _____

Phone: () _____

