



PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

Athletic Physicals in Polk County Public Schools are valid for the academic school year only.

EL2

Revised 3/23

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) print legibly

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/___
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ 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: (____) _____
Student ID#: _____

- 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 healthcare 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.

Provider Stamp (if required by school)

Medications: (use additional sheet, if necessary)

List: _____

Relevant medical history to be reviewed by athletic trainer/team physician: (explain below, use additional sheet, 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.

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Registration for Parents

Go to www.aktivate.com

Click Login

Click Create an Account (You only need ONE account, even if you have children in more than one high school and/or junior high; Do Not create another account if you have used Register My Athlete in the past)

Fill in personal account information (**this should be the Parent's personal information**)

You will be using the site as a Parent

Click Submit

After you have an account:

Login

Under the Parents header (Blue), Click the button labeled "Click here to start/complete athlete registrations". (the first time you log in you will be asked to agree to terms and conditions)

Click Start/Complete a Registration (upper left hand corner of the page)

Click Start a New Registration - **this is where you will enter all of your Athlete's information**

Click on the red bars to complete all requirements

Click the orange button on the lower left side of the screen for live chat 

or email support@aktivate.com for assistance

 Available July 2022, download the Aktivate mobile app for your team communications

