



ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

PLEASE PRINT ALL INFORMATION

Name _____ Birth Date _____ Age _____ Male o Female o

Local Address _____ City _____ State _____ Zip _____

Family Doctor _____ City _____ Sport _____ Position _____

Parent / Guardian Information:

Mother:

Father:

Sport _____ Position _____

In Case of Emergency, Notify:

name _____

name _____

address _____

address _____

name _____

city _____ state _____ zip _____

city _____ state _____ zip _____

relationship _____

() _____
area code phone number

() _____
area code phone number

() _____
area code phone number

MEDICAL HISTORY

DO YOU HAVE NOW, OR HAVE YOU EVER HAD IN THE PAST ANY PROBLEMS OR HISTORY WITH:

- Frequent Headaches NO YES _____
- Heart NO YES _____
- Breathing / Asthma NO YES _____
- Blackouts / Dizzy Spells NO YES _____
- Eyes / Ears / Hearing NO YES _____
- Arthritis NO YES _____
- Knees / Ankles / Feet NO YES _____
- Shoulders / Elbows / Hands NO YES _____
- Back / Neck NO YES _____
- Bladder / Kidney NO YES _____
- Appendix NO YES _____
- Spleen / Mononucleosis NO YES _____
- Liver / Hepatitis NO YES _____
- Abdominal Pain NO YES _____
- Diabetes NO YES _____
- High Blood Pressure NO YES _____
- Sickle Cell Anemia NO YES _____
- Do you wear Glasses NO YES _____
- Do you wear Contact Lenses NO YES _____

- Cancer NO YES _____
- Skin Disorders NO YES _____
- Drug Allergies NO YES _____
- Other Allergies NO YES _____
- Operations / Surgery NO YES _____
- Seizures NO YES _____
- Teeth NO YES _____
- Broken Bones NO YES _____
- Have you ever had as cervical spine injury? NO YES, when _____
- Have you ever been knocked unconscious?
NO YES (How many times _____ When _____)
- Has anyone in your family died of heart related problems?
NO YES (Who / Relation / Age at death) _____
- Do you have a permanent handicap or disability? NO YES _____
- Do you have normal menstrual cycles? (Women) NO YES _____
- Are you under a physicians care at the this time? NO YES _____
- Are you taking any medications or drugs at this time? NO YES _____
- Are you missing a paired organ (Kidney, Eye, Lung, Ovary, Testicle)?
NO YES, (What _____ Circumstances _____)

EXPLAIN ALL YES ANSWERS: _____

I UNDERSTAND THE ABOVE STATEMENTS, AND THE ABOVE QUESTIONS HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY, TO THE BEST OF MY KNOWLEDGE.

ATHLETE SIGNATURE _____ DATE _____

PHYSICAL EXAMINATION
(TO BE COMPLETED BY PHYSICIAN)

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____ U/A: _____ Vision: R: 20/ _____ L: 20/ _____ Both: 20/ _____

	WNL	Abnormal Findings
Head/Scalp/Face/Teeth/Skin	_____	_____
Eyes/Ears/Nose/Throat/Mouth	_____	_____
Lungs	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Urogenital	_____	_____
Nervous System	_____	_____
Lymph Nodes	_____	_____
Extremities:		
Cervical Spine/Neck	_____	_____
Thoracic/Lumbar Spine	_____	_____
Shoulders/Arms	_____	_____
Elbows	_____	_____
Wrists	_____	_____
Hips/Thighs	_____	_____
Knees/Legs	_____	_____
Ankles	_____	_____
Feet	_____	_____

Knee Laxity: None

Right: MCL LCL PCL ACL

Left: MCL LCL PCL ACL

Ankle Laxity: None

Left _____

Right _____

Shoulder Laxity: None

Left _____

Right _____

Comments: _____

CHECK ONE:

- APPROVED FOR INTERCOLLEGIATE ATHLETIC COMPETITION
- CONDITIONAL APPROVAL PENDING FURTHER STUDY: _____
- APPROVED WITH FOLLOWING LIMITATIONS: _____
- DISAPPROVED FOR INTERCOLLEGIATE ATHLETIC COMPETITION: _____

ALL OF FOLLOWING MUST BE INCLUDED:

PHYSICIAN (MD/DO/PAC) SIGNATURE _____ DATE _____

PHYSICIAN NAME (PRINT): _____ OFFICE PHONE: (_____) _____

PHYSICIAN ADDRESS: _____ CITY _____ STATE _____ ZIP _____

OFFICE STAMP: