

Emmanuel College Athletic Department

Pre-participation Physical Exam

Personal Information:

Name of Athlete: _____ Sex (Circle): Male Female
 Last First Middle
 Phone: _____ Date of Birth: ____/____/____ SS# _____
 Sport: _____ Year of Eligibility (Circle): FR SO JR SR

In case of emergency, contact:

1) Name: _____ Relationship: _____
 Phone (Home): _____ Phone (Work/Cell): _____
 2) Name: _____ Relationship: _____
 Phone (Home): _____ Phone (Work/Cell): _____

History: Circle all answers to questions. Explain "YES" answers on next page. Circle questions you don't know the answer to.

<p>1. Have you had a medical illness or injury since your last checkup or sports physical? Yes No</p> <p>2. Do you have an ongoing or chronic illness? Yes No</p> <p>3. Have you ever been hospitalized overnight? Yes No</p> <p>4. Have you ever had surgery? Yes No</p> <p>5. Are you currently taking any prescription or non prescription (over-the-counter) medications or pills or using an inhaler? Yes No</p> <p>6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes No</p> <p>7. Do you have any allergies (to pollen, medicine, food, or stinging insects)? Yes No</p> <p>8. Have you ever had a rash or hives develop during or after exercise? Yes No</p> <p>9. Have you ever passed out during or after exercise? Yes No</p> <p>10. Have you ever been dizzy during or after exercise? Yes No</p> <p>11. Have you ever had chest pain during or after exercise? Yes No</p> <p>12. Do you get tired more quickly than your friends do during exercise? Yes No</p> <p>13. Have you ever had racing of your heart or skipped heartbeats? Yes No</p> <p>14. Have you ever had high blood pressure or high cholesterol? Yes No</p> <p>15. Have you ever been told you had a heart murmur? Yes No</p> <p>16. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No</p> <p>17. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month? Yes No</p> <p>18. Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No</p> <p>19. Is there a history of Marfan's Syndrome in your family? Yes No</p> <p>20. Is there a history of premature (prior to age 50) onset of diabetes in your family? Yes No</p> <p>21. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)? Yes No</p> <p>22. Have you ever been knocked out, become unconscious, or lost your memory? Yes No</p>	<p>23. Have you ever had a seizure? Yes No</p> <p>24. Do you have frequent or severe headaches? Yes No</p> <p>25. Have you ever had numbness or tingling in your arms, legs or feet? Yes No</p> <p>26. Have you ever had a stinger, burner, or pinched nerve? Yes No</p> <p>31. Have you ever become ill from exercising in the heat? Yes No</p> <p>32. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No</p> <p>33. Do you have asthma? Yes No</p> <p>34. Do you have seasonal allergies that require medical treatment? Yes No</p> <p>35. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes No</p> <p>36. Have you had any problems with your eyes or vision? Yes No</p> <p>37. Do you wear glasses, contacts, or protective eyewear? Yes No</p> <p>38. Have you ever had a sprain, strain, or swelling after injury? Yes No</p> <p>39. Have you broken or fractured any bones or dislocated any joints? Yes No</p> <p>40. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No <i>If yes, check the appropriate line and explain below.</i> ___ Head ___ Elbow ___ Hip ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf ___ Shoulder ___ Finger ___ Ankle ___ Upper arm ___ Foot</p> <p>41. Do you want to weigh more or less than you do now? Yes No</p> <p>42. Do you feel stressed out? Yes No</p> <p>43. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____</p>
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For questions 1-43, explain all "Yes" answers here (may use back of form also): _____

FEMALES ONLY

44. When was your first menstrual period? _____
 45. When was your most recent menstrual period? _____
 46. How much time do you usually have from the start of one period to the start of another? _____
 47. How many periods have you had in the last 12 months? _____
 48. What was the longest time between periods in the last 12 months? _____

Is there anything else you would like to discuss with one of our physicians? **YES** **NO**
 If so, please list it here: _____

I, _____ (**printed name**) hereby recognize and verify that all above information is true and accurate to the best of my knowledge, and that I have not intentionally withheld or omitted any other information. I fully understand that the Emmanuel College Athletic Department cannot be held responsible for any previous medical condition(s) I might have. I understand that I will not hold Emmanuel College, or any of its agents, servants, trustees, or employees liable for any injuries and/or illnesses not mentioned on this questionnaire. I/we understand that having passed the physician examination does not necessarily mean I am physically qualified to engage in athletics, but only that the examiner did not find any medical reason to disqualify me. Finally, I/We understand that by performing this examination, the physician does not assume responsibility for the medical care of this individual.

Student-Athlete Signature _____ Date ___/___/_____
 (Parent or guardian signature if athlete is under 18)

FOR MEDICAL PERSONNEL ONLY

Physical Examination

Height _____ Weight _____ Blood Pressure _____ Pulse _____
 Heart Sounds _____ Lung Sounds _____ Pupils: Equal _____ Unequal _____
 Vision: R _____ L _____ Corrected **YES NO**

Musculoskeletal

	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance:

____ Cleared
 ____ Cleared after further evaluation/rehabilitation for: _____

 To be evaluated by: _____ Rehab by: _____
 ____ Not cleared due to: _____
 Recommendations: _____

Physician Signature: _____ Date: ___/___/_____