

PRE-PARTICIPATION ATHLETIC PHYSICAL EXAMINATION

Athlete Name: _____ Age: _____ Banner #: _____

Social Security No: _____ Sport: _____ Phone: _____

STEP ONE Health History (to be completed by athlete):

Circle the appropriate answer (explain "Yes" below):

- | | | |
|--|-----|----|
| Do you have any allergies? | Yes | No |
| Do you take any medicines? | Yes | No |
| Have you ever had a heart murmur? | Yes | No |
| Have you ever had an irregular heartbeat? | Yes | No |
| Has anyone in your family died prior to age 40? | Yes | No |
| Have you ever been hospitalized overnight? | Yes | No |
| Have you ever had surgery? | Yes | No |
| Have you ever had a serious injury? | Yes | No |
| Have you ever had a head injury? | Yes | No |
| Have you ever had x-rays? | Yes | No |
| Have you ever had a broken bone? | Yes | No |
| Have you ever had a sprain/strain/dislocation? | Yes | No |
| Have you ever had a "stinger/burner"? | Yes | No |
| Have you ever passed out? | Yes | No |
| Have you ever had chest pain? | Yes | No |
| Have you ever had high blood pressure? | Yes | No |
| Have you ever had a seizure? | Yes | No |
| Have you ever had heat cramps/exhaustion/stroke? | Yes | No |
| Do you have any chronic diseases? | Yes | No |
- (asthma, diabetes, hepatitis, Marfan's syndrome, Mononucleosis, sickle cell, kidney problems, frequent headaches, etc.)
- | | | |
|---|-----|----|
| Have you ever had any skin conditions? | Yes | No |
| Do you wear glasses, contacts, braces, appliances? | Yes | No |
| Do you need special pads/braces for sports? | Yes | No |
| Females – Do you have regular menstrual periods? | Yes | No |
| Has it been more than 5 years since your last tetanus shot? | Yes | No |
| Do you have any concerns to discuss with the provider? | Yes | No |
| Do you use any nutritional supplements? | Yes | No |

Explain any "Yes" answers from above:

I authorize the release to the Athletic Department of this and any information that may affect my participation in the IUP athletic program. I furthermore know of and accept the risks involved in participation in athletics and understand that serious injury, even death, is possible in such participation and voluntarily choose to accept such risks.

Athlete Signature: _____

Date signed: _____

STEP TWO Provider to complete assessment below:

CHECK IF NORMAL EXPLANATION IF ABNORMAL

Musculoskeletal (ROM, strength)		
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Neck		
Spine		
Shoulders		
Arms/hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
Neuromuscular (DTR)		

Completed by (Provider) _____

STEP THREE Provider to complete assessment:

Ht: _____ Wt: _____ Body Mass Index: _____

Blood pressure: _____ Pulse (resting): _____

Vision: _____ O.D. _____ O.S.

Eyes (incl. funduscopy)		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Chest and Lungs		
Abdomen		
Skin		
Genitalia – Hernia (Male)		

FORM COMPLETE: _____ NOT COMPLETE: _____

(explain) _____

RECOMMENDED FOR FULL PARTICIPATION:

YES _____ NO _____

PARTIAL _____

Provider Name, address and phone:

I have reviewed the above history:

PROVIDER SIGNATURE _____ MD/DO/CRNP

DATE SIGNED: _____

Also discussed:

Stretching _____ Heat Related Issues _____

Ideal Body Weight _____ Acute Injuries _____

Self Exams for cancer detection _____