HIGHLAND COMMUNITY COLLEGE

ATHLETIC PHYSICAL EXAMINATION FORM

Pre-Participation Examination

To be completed by athlete or parent prior to examination.

Athletes Name _____ (Last) _____ (First) _____ (Middle) School Year_____

Athletes Address _____ City_____ State_____ Zip_____

Phone Number (_____)_____ Birthdate_____ Age_____ Student ID_____

Parent's Name _____ Phone Number (_____)_____

Parent's Address _____ City_____ State_____ Zip_____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

***Explain "Yes" answers below. Circle questions you don't know the answers to.**

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports?		
2. Do you have any ongoing medical conditions? Please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other_____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
1. Have you ever passed out or nearly passed out during or after exercise?		
2. Have you ever had discomfort, pain, tightness, in your chest during exercise?		
3. Does your heart ever race or skip beats (irregular beats) during exercise?		
4. Has a doctor ever said that you have heart problems? Check all that apply: ☐ Heart murmur ☐ High cholesterol ☐ Heart infection Other_____		
5. Has a doctor ever ordered a test for your heart? (For example: ECG/EKG, echocardiogram)		
6. Do you get lightheaded or feel short of breath during exercise?		
7. Have you ever had an unexplained seizure?		
8. Do you get more tired or short of breath quicker than others during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
1. Has any family member or relative died of heart problems or unexpected sudden death before age 50? (include drowning, car accidents, SIDS)		
2. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
1. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
2. Have you ever had any broken or fractured bones or dislocated joints?		
3. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
4. Have you ever had a stress fracture?		
5. Have you ever had been told or x-rayed for neck, instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
6. Do you regularly use a brace, orthotics, or other assistive device?		
7. Do you have a bone, muscle, or joint injury that bothers you?		
8. Do any of your joints become painful, swollen, feel warm, or look red?		
9. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
1. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
3. Have you ever used an inhaler or taken asthma medicine?		
4. Is there anyone in your family who has asthma?		
5. Do you have groin pain or a painful bulge or hernia in the groin area?		
6. Have you had infectious mononucleosis (mono) within the last month?		
7. Do you have any rashes, pressure sores, or other skin problems?		
8. Have you had a herpes or MRSA skin infection?		
9. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
10. Have you ever been unable to move your arms or legs after being hit or falling?		
11. Do you have headaches with exercise?		
12. Have you ever become ill while exercising in the heat?		
13. Do you get frequent muscle cramps when exercising?		
14. Do you or someone in your family have sickle cell trait or disease?		
15. Have you had any problems with your eyes or vision?		
16. Have you had any eye injuries?		
17. Do you wear glasses or contact lenses?		
18. Do you wear protective eyewear, such as goggles or a face shield?		
19. Do you worry about your weight?		
20. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Are you on a special diet or do you avoid certain types of foods?		
22. Have you ever had an eating disorder?		
23. Have you or any family member or relative been diagnosed with cancer?		
24. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	***Yes***	***No***
1. Have you ever had a menstrual period?		
2. How old were you when you had your first menstrual period?		
3. How many periods have you had in the last 12 month?		
***Explain "Yes" answers here:**		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student/Athlete_____ Date_____

Signature of Parent/Guardian_____ **Date**_____

***Return this form to Highland College Athletic Department office**

HIGHLAND COMMUNITY COLLEGE

ATHLETIC PHYSICAL EXAMINATION FORM

Pre-Participation Examination

PHYSICAL EXAMINATION FORM

EXAMINATION		
Height Weight ☐ Male ☐ Female		
Blood Pressure Pulse Vision R 20/_____ Vision L 20/ _____ Corrected ☐ Yes ☐ No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS (Explain)**
Appearance ▪ Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, Arachnodactyly, arm span > height, hyperiaxity, myopia, MVP, aortic insufficiency)	☐	
Eyes/ears/nose throat ▪ Pupils equal ▪Hearing	☐	
Lymph nodes	☐	
Heart ▪ Murmurs (auscultation standing, supine, +/-Valsalva) ▪ Location of point of maximal impulse (PMI)	☐	
Pulses ▪ Simultaneous femoral and radial pulses	☐	
Lungs	☐	
Abdomen	☐	
Genitourinary (Males only)	☐	
Skin ▪ HSV, lesions suggestive of MRSA, tineacorporis	☐	
Neurologic	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS (Explain)**
Neck	☐	
Back	☐	
Shoulder/Arm	☐	
Elbow/Forearm	☐	
Wrist/Hand/Fingers	☐	
Hip/Thigh	☐	
Knee	☐	
Leg/Ankle	☐	
Foot/Toes	☐	
Functional ▪ Duck-walk, single leg hop	☐	

On the basis of the examination on this day, I approve this student/athletes participation in interscholastic sports for one year.

☐ **Yes** ☐ **No** ☐ **Limited** *** Examination Date**_____

Additional Comments:

_____

_____

_____

_____

_____

Physician's Signature_____ **Date**_____

Physician's Assistant Signature_____ **Date**_____

Advanced Nurse Practitioner's Signature_____ **Date**_____

***Return this form to the Highland College Athletic Department office**