

Emerson College
Athletic Training Department
Physical Form

Part A – History

Date of EXAM _____

Student's Name _____ Sex _____ Age _____

Address _____

DOB: _____ Sport(s): _____

Insurance Name: _____

Address: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Tel(H) _____ (W) _____ (M) _____

Relationship: _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had any medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized in the last year? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any prescription or over-the-counter medication on a permanent or semi-permanent basis? (inhaler, anti-inflammatories, antibiotics, steroids, birth control pills) | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken any supplements or vitamins to help you gain or lose weight to improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> | <i>If yes, circle area and explain below:</i> | | |
| 7. Do you currently have or have had with exercise any skin problems? (rash, itching, warts, fungus, blisters) | <input type="checkbox"/> | <input type="checkbox"/> | Head | Elbow | Hip |
| 8. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Neck | Forearm | Thigh |
| 9. Have you ever passed out or been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Back | Wrist | Knee |
| 10. Do you get tired more quickly than your friends do your exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Chest | Hand | Shin/Calf |
| 11. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder | Finger | Ankle |
| 12. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | Upper Arm | | Arm |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Do you lose weight regularly to meet weight requirements for you sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last 3 months? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Record the dates of your most recent immunizations (shots) for: | | |
| 15. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ Measles _____ | | |
| 16. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ Chickenpox _____ | | |
| 17. Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES ONLY: | | |
| 18. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | 33. When was your menstrual period? _____ | | |
| 19. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 34. When was your most recent menstrual period? _____ | | |
| 20. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> | 35. How much time do you usually have from the start of one period to the start of another? _____ | | |
| 21. Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | 36. How many periods have you had in the last year? _____ | | |
| 22. Do you have asthma, cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> | 37. When was the longest time between periods in the last year _____ | | |
| 23. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | <i>Explain any "yes" answers here:</i> | | |
| 24. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| 25. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position(for example, knee brace, foot orthotics, retainer for your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | _____ |
| | | | _____ | _____ | _____ |
| | | | _____ | _____ | _____ |

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Signature of Athlete _____ Date: _____

Signature of Parent-Gurdian/Date (if under 18) _____ Date: _____

PART B – PHYSICAL EXAMINATION (completed by medical professional)

STUDENT (please print) _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP _____/_____

	NORMAL	ABNORMAL FINDINGS and COMMENTS
MEDICAL		
Skin/Lymphatic		
HEENT		
Chest/Lungs		
Cardiovascular		
Abdomen		
Genitalia (males only)/hernia		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
NEUROLOGICAL		

PART C – Participation Recommendations (completed by medical professional)

___ There were no history or physical findings on this examination that would prohibit this student from participating in competitive athletics.

___ This student should have the following health problems evaluated or treated prior to participating in competitive athletics.

___ This student has health problems that would prohibit him or her from participating in competitive athletics.
Reason(s):

Name of Provider (please print): _____

Signature of Provider: _____ Date: _____

Address: _____ Tel: _____