

Northern Essex Community College Athletic Participation Physical Exam Form

Name _____ Date _____ DOB _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____

Circle all programs you plan to participate in:

	W. Volleyball	W. Basketball
	M. Basketball	M. Baseball
	Track & Field	

****BOTH SIDES OF THIS FORM AND THE ATTACHED IMMUNIZATION FORM MUST BE FILLED OUT COMPLETELY AND RETURNED!****

Part I – Medical History

This form must be completed by the student and signed, prior to the physical examination, for review by examining physician.

Explain all "Yes" answers below:

- | | Yes | No | Has the student had any? | | Yes | No | Has the student had any? |
|-----|-------|-------|--|---|-------|-------|---|
| 1. | _____ | _____ | Hospitalizations? | 12. | _____ | _____ | Headaches with exercise? |
| 2. | _____ | _____ | Surgery? | 13. | _____ | _____ | Confusion or memory loss after head injury? |
| 3. | _____ | _____ | Chronic or recurrent illness? | 14. | _____ | _____ | Epilepsy or other seizures? |
| 4. | _____ | _____ | Illness lasting longer than 1 week? | 15. | _____ | _____ | Asthma? |
| 5. | _____ | _____ | Missing organs? | 16. | _____ | _____ | Diabetes? |
| 6. | _____ | _____ | Allergies to medications, insects, food, seasonal? | 17. | _____ | _____ | Heat exhaustion, heat stroke, or heat cramps? |
| 7. | _____ | _____ | Skin problems/disorders? | 18. | _____ | _____ | Eyeglasses or contact lenses? |
| 8. | _____ | _____ | Problems with heart, blood pressure, or cholesterol? | Females Only | | | |
| 9. | _____ | _____ | Racing of your heart or skipped heartbeats? | How many periods have you had in the last 12 months? _____ | | | |
| 10. | _____ | _____ | Chest pain, dizziness, or fainting with exercise? | What was the longest time between your periods last year? _____ | | | |
| 11. | _____ | _____ | Concussions, unconsciousness, or extremity numbness? | | | | |

Please explain all "Yes" answers _____

List all medications you are currently taking (include birth control pills, asthma inhalers, herbal and sport related supplements.) _____

List injuries and surgeries to the following areas: Please be specific with details and dates.
 Concussion/Head Injury/ "Bell Rung" _____
 Back _____
 Neck _____
 Shoulders _____
 Elbows/Wrists/Hands/Fingers _____
 Hips/Knees _____
 Ankles/Feet/Toes _____

Student's Signature _____ Date _____

Part II – Physical Examination

To be completed by MD, DO, PA, or ARNP

Athlete's Name _____ DOB _____ Sport Participation _____

Height _____ Weight _____ BP _____ P _____ Vision R: _____ L: _____ Corrective Lenses? Y N

	FINDINGS
Mental/Emotional Status	
HEENT	
Skin	
Neck, Thyroid	
Lungs	
Lymph Nodes	
Abdomen	
Extremities/Spine	
Neurological	
Genitals/Hernia	
Heart (Murmur/Dysrhythmia?)	
Femoral Artery Pulses	
Recognition of Marfan Syndrome	
Pertinent Past Medical History	
Current Medications	
Allergies to Meds/Food/Other	
Sickle Cell Trait	

Additional Comments regarding abnormal findings _____

Athletic Participation Recommendations

I have reviewed the data above, including the athlete's medical history form and make the following recommendations for his/her participation in athletics.

- _____ CLEARED WITHOUT RESTRICTIONS
- _____ Cleared AFTER further evaluation or treatment for _____
- _____ NOT CLEARED due to _____

Other recommendations _____

Physician Signature _____ *Date of Examination* _____
 (MD, DO, PA, ARNP)

Examiner's Name and Degree (Print) _____ Phone _____

Address _____ Date Signed _____