

# 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  
M. Basketball  
Track & Field

Cross Country  
M. Baseball  
Softball

**\*\*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?                             |
|-----------|-------|--|
| 1. _____  | _____ | Hospitalizations?                                    |
| 2. _____  | _____ | Surgery?   |
| 3. _____  | _____ | Chronic or recurrent illness?                        |
| 4. _____  | _____ | Illness lasting longer than 1 week?                  |
| 5. _____  | _____ | Missing organs?                                      |
| 6. _____  | _____ | Allergies to medications, insects, food, seasonal?   |
| 7. _____  | _____ | Skin problems/disorders?                             |
| 8. _____  | _____ | Problems with heart, blood pressure, or cholesterol? |
| 9. _____  | _____ | Racing of your heart or skipped heartbeats?          |
| 10. _____ | _____ | Chest pain, dizziness, or fainting with exercise?    |
| 11. _____ | _____ | Concussions, unconsciousness, or extremity numbness? |

- | Yes       | No    | Has the student had any?                      |
|-----------|-------|---|
| 12. _____ | _____ | Headaches with exercise?                      |
| 13. _____ | _____ | Confusion or memory loss after head injury?   |
| 14. _____ | _____ | Epilepsy or other seizures?                   |
| 15. _____ | _____ | Asthma?                                       |
| 16. _____ | _____ | Diabetes?                                     |
| 17. _____ | _____ | Heat exhaustion, heat stroke, or heat cramps? |
| 18. _____ | _____ | Eyeglasses or contact lenses?                 |

### Females Only

How many periods have you had in the last 12 months? \_\_\_\_\_  
What was the longest time between your periods last year? \_\_\_\_\_

**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, DC, 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, DC ARNP)

**Examiner's Name and Degree (Print)** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Date Signed \_\_\_\_\_