



Pre-Participation Physical Examination

Name: _____ Sport: _____

SS#: _____ - _____ - _____ Date of birth: ____ / ____ / _____ Sex: M F

Permanent (home) address: _____
Street City State Zip Phone

My permanent address is with: mother father both biological parents

Local address: _____
Street City State Zip Phone

Cell Phone: _____

EXPLAIN YES ANSWERS IN SPACE PROVIDED

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? (explain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? (explain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? If yes, what are they? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? If yes, when? (year) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked unconscious? If yes, when? (year) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? If yes, when? (year) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? If yes, when? (year) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, mouth guard, eye guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |

Pre-Participation Physical Examination (continued)

Yes No

11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?
- Please check: head shoulder thigh neck elbow
 chest hand forearm back shin/calf ankle
 wrist hip knee foot
12. Have you had any other medical problems?
- asthma anemia hypoglycemia diabetes infectious mononucleosis other
13. When was your last tetanus shot? (year) _____
14. Do you smoke?
- Use other tobacco products?
15. What is your present weight? _____ lbs.
16. Are you happy with this weight?
- If not, what would you like to weigh? _____ lbs.
17. Have you ever tried to control your weight by:
- a) vomiting?
- b) using laxatives?
- c) taking diuretics (water pills)?
- d) diet pills?
18. Have you ever been diagnosed as having an eating disorder?
19. Do you have questions about healthy ways to control weight?
20. Are there any additional health problems that you would prefer to discuss privately with our team physician?

Women Only

-
21. When was your first menstrual period? _____
22. When was your last menstrual period? _____
23. What was the longest time between your periods last year? _____
24. Is there a possibility that you could be pregnant?
25. How many urinary tract infections (bladder/kidney) have you had in the last year? _____
26. Have you ever had a pelvic (female) exam?
- When was your last pelvic exam? _____
- Have you ever had an abnormal PAP smear?

Please read carefully and sign below

I understand that failure to disclose accurate information could result in my being ineligible to participate in practices or events on a Daytona State College inter-collegiate athletic team. I understand I must not practice or play during medical treatment for any injury or illness until I am discharged from treatment or given a written permit by the attending physician to resume participation. I understand that having passed the physical examination does not necessarily mean that I am physically qualified to participate in athletics, but only that the examiner did not find a medical reason to disqualify me. I understand that Daytona State College is not financially responsible for injury or illness that occurs outside a Daytona State College scheduled and sanctioned practice or event. I understand that failure to follow the procedures outlined in the Athletic Injury, Illness and Medical Care Procedures Brochure will result in my being ineligible to participate in practices or events on a Daytona State College intercollegiate athletic team.

Athlete's printed name

Athlete's signature

Parent's signature (if minor): _____

Pre-Participation Physical Examination (continued)

Physical Examination

Date: _____

Name: _____ Age: _____ Date of birth: ____/____/____

COMPLETE	LIMITED	Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____					
		Vision R 20/_____ L 20/_____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N Pupils: _____					
		Normal	Abnormal Findings				Initials
	Cardiopulmonary						
	Pulses						
	Heart						
	Lungs						
	Tanner stage	1	2	3	4	5	
	Skin						
	Abdominal						
	Genitalia						
	Musculoskeletal						
	Neck						
	Shoulder						
	Elbow						
	Wrist						
	Hand						
	Back						
	Knee						
	Ankle						
Foot							
Other							

Clearance

- A. Cleared
- B. *Provisional*: Cleared after completing evaluation/rehabilitation for: _____
- C. *Hold*: Not cleared for: Collision Contact
 Non-contact *strenuous* *moderately strenuous* *non-strenuous*
 Due to: _____

Recommendation: _____

Physician name : _____

Address: _____ ()
Street City State Zip Phone

Physician signature : _____ Date: _____

(Developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine. Copyright © 1992.)