Athletic Physical Exam (By Doctor)
Complete other side *prior* to examination

Complete and return this form ONLY if you will be participating in Warrior Athletics.

Height_____ Weight_____ Pulse_____ Blood Pressure _____

Visual Acuity: Uncorrected_____ Corrected_____ Pupils Equal Diameter: Y N

Mouth: Appliances: Y N Missing/loose teeth: Y N Cavities in need of treatment: Y N

Skin: Any infectious lesion? Y N

Respiratory: Symmetrical breath sounds: Y N Wheezes: Y N

Cardiovascular: Rate _____ Irregularities: Y N

Murmur: Y N Murmur with valsalva: Y N

Peripheral pulses equal: Y N

Abdomen: Masses: Y N Splenomegaly: Y N Hepatomegally: Y N

Genitourinary: Inguinal hernia: Y N Testicles descended bilaterally: Y N

Musculoskeletal: (Note any abnormalities)

Neck: Y N	Knee/Hip: Y N
Shoulder: Y N	Ankle: Y N
Elbow: Y N	Hamstrings: Y N
Wrist: Y N	Scoliosis: Y N

RECOMMENDATION BASED ON ABOVE EVALUATION:

After my evaluation, I give my

____ Full approval

____ Full approval, but needs further evaluation by family Dentist ___; Eye Doctor ___; Family Physician ___; Other _____

____ Limited approval with the following restrictions:_____

____ Denial of approval for the following reasons: _____

_____

_____ M.D./D.O.

(Signature)

_____

(Date)

Revised 12/9/2008

Athlete's Medical History

(To be completed by parent/guardian or student prior to doctor's examination)
Complete and return this form ONLY if you will be participating in Warrior Athletics

Name of Student_____ Birthdate_____ Age_____

Social security # _____-_____-_____ Gender M F Height _____ Weight _____

Home Phone #_____ E-mail Address _____

I would like to play: [ ] Men's Soccer [ ] Men's Basketball [ ] Women's Volleyball [ ] Women's Basketball

Sport	Position	# of Seasons Played	High School Name and Phone #	Last Coach's Name and Phone #
Soccer				
Volleyball				
Basketball				

Transfer Student? Yes No If yes, transfer from_____

Semesters Completed _____ Intercollegiate Seasons Played _____

Soccer and Volleyball ONLY: I **will** be at the pre-season practices. **Yes** **No**
If you cannot attend pre-season training but would still like to try out, please list the reason you cannot attend:

Have you ever had:

Yes No 1. Chronic or recurrent illnesses? (Diabetes, Asthma, Seizures…)
Yes No 2. Any hospitalizations?
Yes No 3. Any surgery (except tonsils)?
Yes No 4. Any injuries that prohibited your participation in sports?
Yes No 5. Dizziness, fainting, or frequent headaches?
Yes No 6. Concussion/knocked out?
Yes No 7. Knee, ankle, or neck injuries?
Yes No 8. Broken bone or dislocation?
Yes No 9. Heat exhaustion/sun stroke?

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS:

Do you:

Yes No 10. Have any allergies?
Yes No 11. Have any problems with heart/blood pressure?
Yes No 12. Has anyone in your family ever fainted during exercise?
Yes No 13. Take any medication? List: _____ _____
Yes No 14. Wear glasses_____ contact lenses_____ dental appliances_____ ?
Yes No 15. Have any organs missing? (eye, kidney, testicle, etc.)
Yes No 16. Has it been longer than 10 years since your last tetanus shot?
Yes No 17. Have you ever been told not to participate in any sport?
Yes No 18. Do you know of any reason you should not participate in sports?
Yes No 19. Have a sudden death history in your family?
Yes No 20. Have a family history of heart attacks before age 50?

I also give my consent for the physician in attendance and appropriate medical staff to give treatment at any athletic event for any injury.

_____ _____
Signature of Parent or Guardian (if student under age 18) Date

_____ _____
Student Signature Date

Revised 12/9/2008