This form should be submitted with a copy of the player's most recent physical (must be within last 12 months)

PART A – PERSONAL PHYSICAL EXAMINATION

To be completed by a medical doctor

Athlete's Name: _____ Height: _____ Weight _____ BP _____/_____

Resting Pulse: _____ Visual acuity (uncorrected) R ____ / ____ L ____ / ____ (corrected): R ____ / ____ L ____ / ____

Color Blindness _____ EENT, thyroid: _____ Teeth _____

Chest: _____

Cardiovascular: _____

Abdomen (including hernias, testicles): _____

CNS: _____ DTR's: _____Skin _____

Musculoskeletal (*please note any evidence of prior injury, instability, or loss of flexibility*)

Hand/Wrist: _____

Elbow: _____

Shoulder: _____

Neck/Back: _____

Hip/Pelvis: _____

Knee: _____

Ankle/Feet: _____

Additional Comments/ Abnormal Findings:

_____

_____

_____

Laboratory (If indicated) CBC _____ Urine _____
others (as indicated):

X-rays (as indicated):

Recommendations re: Participation:	Notes:
No restrictions (Contact/Collision)	_____
Limited Contact/Impact	_____
Non-Contact	_____
Strenuous	_____
Moderate	_____
Non-strenuous	_____
Needs further consultation/tests	_____
Not fit	_____

Recommendations prior to participation (e.g., rehabilitation):

_____

_____

Examining Physician (Print): _____ Physician's Signature: _____

Address: _____ City: _____ Postal Code: _____

Date of examination: _____ Phone ( ): _____

PART B – PERSONAL HEALTH HISTORY

Please check any of the following that apply and note next to each the diagnosis and date when the condition started.

1. ALLERGIES/ ADVERSE REACTIONS TO MEDICATIONS/FOOD/INSECTS/OTHER?☐ No ☐ Yes-please specify below

☐**Aspirin** ☐**Codeine** ☐**Penicillin/Ampicillin** ☐**Sulfa** ☐**Other**

2. DO YOU TAKE ANY MEDICATIONS ON A FREQUENT OR REGULAR BASIS?☐ No ☐ Yes-please specify below

Please list ALL prescription AND nonprescription medications AND nutritional supplements that you use on a recurring basis including medications for problems such as Acne, Allergies, Anemia, Anxiety, Asthma, Birth Control, Bowel Disorders, Depression, Diabetes, Epilepsy, Seizures, High Blood Pressure, Pain, or Sleep. _____

3. HAVE YOU EVER HAD ANY HEALTH PROBLEMS, SURGERIES/OPERATIONS, OR HOSPITALIZATIONS?

Check each item:	**No**	**Yes**	**Diagnosis/Date**	**Check each item:**	**No**	**Yes**	**Diagnosis/Date**
Alcohol or drug problems				Fractures Broken Bones			
Appendectomy				Heart condition, disease, or murmur			
Asthma				HIV test – HIV disease, or AIDS			
Attention Deficit Hyperactivity Dis.				High Blood Pressure			
Cancer, leukemia, or lymphoma				Migraine Headaches			
Chicken Pox Varicella				Mononucleosis Epstein-Barr Virus			
Cholesterol or lipid problems				Radiation treatment to head, neck			
Depression				Sexually Transmitted Diseases			
Diabetes Mellitus				Splenectomy			
Eating Disorder Anorexia, Bulimia				Tonsillectomy			
Emotional Mental problems				Transfusion of blood, blood product			
Epilepsy Seizure Disorder				Viral Hepatitis (specify – A, B)			
Other surgery/medical:							

4. DO YOU CURRENTLY HAVE A DISABILITY? ☐ No ☐ Yes-please specify below

☐ Emotional/Mental ☐ Hearing ☐ Learning ☐ Locomotion ☐ Other Motor ☐ Vision ☐Other:_____

5. MISCELLANEOUS HEALTH QUESTIONS – WHICH OF THE FOLLOWING APPLY TO YOU?

☐ No ☐ Yes 1. Do you smoke ☐ tobacco cigarettes, ☐ cigars, or ☐ pipe, or use ☐ chewing tobacco , ☐ dip, or ☐ snuff?

☐ No ☐ Yes 2. Do you drink beverages containing alcohol, such as beer, wine, or distilled spirits?

☐ No ☐ Yes 3. Do you ☐ smoke marijuana or ☐ use other street drugs, such as LSD or cocaine?

☐ No ☐ Yes 4. Have you ever had significant exposure to hazardous substances (e.g., ☐ asbestos, ☐ benzene, ☐ lead, ☐ mercury, ☐ pesticides)?

☐ No ☐ Yes 5. Have you interrupted school or work because of a ☐ physical illness or ☐ an emotional mental illness?