

Have you ever had an illness/injury involving the following?

Head	Yes _____ No _____	Hand	Yes _____ No _____
Shoulder	Yes _____ No _____	Calf	Yes _____ No _____
Wrist	Yes _____ No _____	Heart	Yes _____ No _____
Hip	Yes _____ No _____	Back	Yes _____ No _____
Knee	Yes _____ No _____	Elbow	Yes _____ No _____
Foot	Yes _____ No _____	Chest/Breast	Yes _____ No _____
Neck	Yes _____ No _____	Abdomen/Pelvis	Yes _____ No _____
Arm	Yes _____ No _____	Ankle	Yes _____ No _____

Please explain fully if "YES" to any question above including any surgeries:

Has a doctor ever denied or restricted your participation in sports for any reason (illness, concussion, blood pressure, etc.?)

List all current medications (including birth control pills, vitamins and supplements):

Date of last Tetanus shot: _____

List all medications to which you are allergic (include reaction):

Have you ever been knocked out, become unconscious, or lost your memory? (Explain--how many times, date of your last concussion, etc.)

Have you had any surgeries in the past year? Are you cleared to participate in sports at Southwestern College?

Were you born without or are you missing a kidney, an eye, testicles, or any other organ? (Explain)

Have you ever been unable to move your arms or legs after being hit or falling?

Have you ever had any injury or illness than those already covered?

Has anyone in your family, under the age of 50 died suddenly of the following?

Marfan's Syndrome?	Yes _____ No _____	Heart Trouble?	Yes _____ No _____
Diabetes?	Yes _____ No _____	High Blood Pressure?	Yes _____ No _____
Asthma or Allergies?	Yes _____ No _____	A Stroke?	Yes _____ No _____
HCM or Long QT?	Yes _____ No _____	Bleeding or Circulatory Problems?	Yes _____ No _____

Please explain fully if "YES" to any question above:

Sickle Cell Anemia

- 1) Have you ever been tested for Sickle Cell Anemia that you are aware of?
Yes _____ No _____
 - a. Date: _____
 - b. Result?

- 2) Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of?
Yes _____ No _____
 - a. Please describe :

- 3) Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia?
Yes _____ No _____
 - a. Please describe:

Females only

- 1) When was your first menstrual period? _____
 - 2) When was your most recent menstrual period? _____
 - 3) How many periods have you had in the last year? _____
 - 4) How long are your periods? _____
 - 5) Have you ever been treated for anemia (low hemoglobin or iron)? _____
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I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Athlete's Signature: _____ Date: _____

Physical Portion

Name: _____ Date: _____ Sport(s): _____
Height: _____ (in) Weight: _____ (lbs)
Pulse: _____ Blood Pressure: _____ / _____
Vision: R 20 / _____ L 20 / _____ Corrected: Yes ___ No ___
Pupils: Equal ___ Unequal ___

Orthopedic Screening

Neck/Spine	
Shoulders/Arm	
Hands/Wrists	
Back	
Hips/Thighs	
Knees	
Ankles/Feet	

General Medical Screening

Eyes	
Ears	
Mouth/Throat	
Chest/Lungs	
Heart	
Abdomen	
Genitalia (Males only)	

Participation Recommendations:

Pass

Pass with conditions: _____

Fail: _____

Recommendations: _____

The following information must be filled in and signed by either:

- 1) Physician (MD or DO)
- 2) Physician Assistant (PA-C)
- 3) Registered Nurse Practitioner (ARNP)

****Examination forms signed by any other health care practitioner will not be accepted.****

Physician's Name: _____ Date: _____

Address: _____

Street/PO Box

City

State

Zip

Physician's Phone: _____

Physician's Signature: _____

Must be completed before a student participates in any practice, (both in-season and out-of-season) or games/matches.