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?