Cornell College Athletics
Preparticipation Physical Evaluation

ATHLETE INFORMATION FORM

2017-2018
Cornell College Pre-Participation Physical Evaluation for ***RETURNING*** Student-Athletes.
This physical must be completed and returned to Cornell College's Sports Medicine Department.
All returning athletes must have the athlete information, history, physical exam, and clearance from completed and turned in by ***Friday/ July 31, 2017*** for **fall** sports and refer to checklist for other sports before they will be allowed to participate/ practice in any athletics at Cornell College.

Printed Name:_____ Year: FR SO JR SR Gender: Male Female

Date of Birth: ___/___/___ Cornell Student ID Number:_____

Sports Participating in at Cornell:_____

Athlete's Cell Phone Number:_____

College Address (mailbox #) and **Phone Number:**

Home Mailing Address and **Phone Number:**

Emergency Contacts: ***Two of these MUST be filled out or your physical will be returned*.**

Contact name / relationship to you/ day time phone number:

Contact name/ relationship to you/ day time phone number:

Insurance Information:

***All* student-athletes participating in Cornell College athletics are required to show proof of a primary insurance policy during your competition season. This policy may be part of your parents/guardians primary insurance policy or may be in the athlete's own name. Please also make sure that your primary insurance covers you in the Mount Vernon, Iowa area. If it does not you may be required to purchase additional primary insurance.**

Student-Athletes *MUST INCLUDE* a copy of their insurance card (*FRONT* & *BACK*) with this completed physical

Concussion History:

Have you ever had a head injury/concussion(s)? YES NO
If "yes" to concussions, how many have been diagnosed by a physician? _____

Have you ever been knocked out or unconscious? YES NO
If "yes" to being knocked out of unconscious, how many times? _____

I hereby state that, to the best of my knowledge, my answers to all of the questions on this form are correct.

Athlete's Signature_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

HISTORY FORM

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Date of exam_____

Name_____ Sex___ Age___ Birthdate_____ Sport_____
Last First MI

Year in School_____ SSN_____ Cell #_____

School Address_____

Parent's Name_____

Explain "Yes" answers below
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition? (like diabetes or asthma)	☐	☐
3. Are you currently taking any prescription or non-prescription (OTC) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (Check all that apply): ☐High blood pressure ☐A heart murmur ☐High cholesterol ☐A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, Echocardiogram)	☐	☐
11. Has anyone in your family died under the age of 50 for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before the age of 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ toes

20. Have you ever had a stress fracture?	☐	☐
21. Do you regularly use a brace or assistive device?	☐	☐
22. Has a doctor ever told you that you have asthma or allergies?	☐	☐
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
24. Is there anyone in your family who has asthma?	☐	☐
25. Have you ever used an inhaler or taken asthma medicine?	☐	☐
26. Were you born without or are you missing a kidney, eye, a testicle, or any other organ?	☐	☐
27. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
28. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
29. Have you had a herpes skin infection or cold sore?	☐	☐
30. Have you ever had a head injury or concussion?	☐	☐
31. Have you been hit in the head and been confused or lost your memory?	☐	☐
32. Have you ever had a seizure?	☐	☐
33. Do you have headaches with exercise?	☐	☐
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
35. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
36. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
37. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
38. Have you had any problems with your eyes or vision?	☐	☐
39. Do you wear glasses or contact lenses?	☐	☐
40. Do you wear protective eyewear?	☐	☐
41. Are you happy with your weight?	☐	☐
42. Are you trying to gain or lose weight?	☐	☐
43. Has anyone recommended you change your weight or eating habits?	☐	☐
44. Do you limit or carefully control what you eat?	☐	☐
45. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
46. Have you ever had a menstrual period?	☐	☐
47. How old were you when you had your first menstrual period?	_____	
48. How many periods have you had in the last 12 months?	_____	

Explain "Yes" answers here:_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Adapted from the 2004 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
Signature of athlete_____ Signature of parent/guardian_____ Date_____

PHYSICAL EXAMINATION FORM

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Name_____ Birthdate_____ SSN#_____
Last First MI

Height_____ Weight_____ Sport(s)_____ Pulse_____ BP___/_____

Vision R 20/_____ L 20/_____ Corrected ☐ Yes ☐ No Pupils: Equal_____ Unequal_____

Follow-Up Questions on More Sensitive Issues	**Yes**	**No**
1. Do you feel Stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	☐	☐
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	☐	☐
6. During the past 30 days, have you had at least 1 drink of alcohol?	☐	☐
7. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐

Notes:_____

_____

	Normal	**Abnormal Findings/Notes**
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
LAB/TEST (if appropriate)		
Hgb/Hct		
Ferritin		
Sickle Cell Trait	Negative	Positive (May sign waiver if decline test)
Please check appropriate box		

Name of Physician (print/type):_____ Date:_____

Address:_____ Phone:_____

Signature of Physician_____, MD or DO

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PHYSICIANS: PLEASE MAKE SURE YOU SIGN CLEARENCE FORM AS WELL

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CLEARANCE FORM

Name_____ Sex_____ Age_____ Date of Birth_____

☐ Cleared without restrictions

☐ Cleared, with recommendation for further evaluation or treatment for:_____

_____

_____

_____

☐ Not cleared for: ☐ All Sports ☐ Certain Sports:_____ Reason:_____

Recommendations:_____

_____

EMERGENCY INFORMATION

Allergies_____

Other information_____

IMMUNIZATIONS (eg, tetanus/diphthera/pertussis; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date ☐ Not up to date Specify_____

Name of Physician (print/type):_____ Date:_____

Address:_____ Phone:_____

Signature of Physician_____, MD or DO

I hereby authorize the Ebersole Student Health Center to release any information related to my athletic participation to the Cornell College's Sports Medicine Department. And for Cornell College's Sports Medicine Department to release any medical information to Ebersole Student Health Center or to Cornell College's Insurance Company claims administration services.

Athlete Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Please return to:

Sports Medicine Department
Cornell College
Multi-Sport Center
600 1st Street SW
Mount Vernon, IA 52314

Questions can be directed to: Loren Nydegger LAT, ATC, CSCS
319-895-4573

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