

Midway College

Student-Athlete Pre-participation Medical History / Sport Physical Form

Student Information

Student Name _____ Gender F Date _____
Last First Middle Initial

SSN _____ - _____ - _____ Age _____ Birth Date _____ 2010-11 Sport eligibility year: FR SO JR SR

Cell phone (_____) _____ - _____ Campus phone x _____ NA / Off-campus Sport(s): **BB CC EQ: H W SC SB TN TR VB**

Permanent address _____ City _____ ST _____ Zip _____

Parent(s) or Primary Emergency Contact Information

Name(s) _____ Relationship _____
 Same as permanent address above
 Address _____ City _____ ST _____ Zip _____
 (Please circle) Work / Daytime phone (_____) _____ - _____ Home / Evening phone (_____) _____ - _____ Cell phone (_____) _____ - _____

Name(s) _____ Relationship _____
 Same as permanent address above
 Address _____ City _____ ST _____ Zip _____
 (Please circle) Work / Daytime phone (_____) _____ - _____ Home / Evening phone (_____) _____ - _____ Cell phone (_____) _____ - _____

Secondary Emergency Contact Information

Name(s) _____ Relationship _____
 Address _____ City _____ ST _____ Zip _____
 (Please circle) Work / Daytime phone (_____) _____ - _____ Home / Evening phone (_____) _____ - _____ Cell phone (_____) _____ - _____

Medical History

This section is to be carefully completed by the student and her parent(s) or legal guardian(s) before participation in Midway College athletics in order to help detect possible risks.

If answering "Yes," please check the box next to the question. A blank box indicates a "No" answer.

Explain "Yes" answers in the provided spaces following / below each section. Circle questions if you don't know the answer.

General (explain answers on following page)

- | | |
|--|--|
| <p><input type="checkbox"/> 1. a) Have you had a medical illness or injury since your last checkup or sports physical?</p> <p><input type="checkbox"/> b) Do you have an ongoing or chronic illness?</p> <p><input type="checkbox"/> i. Do you have diabetes?
 a. Are you insulin dependent? Y N</p> <p><input type="checkbox"/> 2. a) Have you ever been hospitalized overnight?</p> <p><input type="checkbox"/> b) Have you ever had surgery?</p> <p><input type="checkbox"/> 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?</p> <p><input type="checkbox"/> 4. Have you had any childhood diseases (ex: measles, mumps, chicken pox)?</p> <p><input type="checkbox"/> 5. Have you ever had a rash or hives develop during or after exercise?</p> <p><input type="checkbox"/> 6. a) Do you have any allergies (ex: medicine, stinging insects, food, or environmental [pollen, dust, etc.]?)</p> <p><input type="checkbox"/> b) Have you ever been advised/prescribed to carry an anaphylactic kit or EpiPen?</p> <p><input type="checkbox"/> c) Do you have a current anaphylactic kit or EpiPen?</p> | <p><input type="checkbox"/> 7. a) Have you ever passed out or nearly passed out <i>during</i> exercise?</p> <p><input type="checkbox"/> b) Have you ever passed out or nearly passed out <i>after</i> exercise?</p> <p><input type="checkbox"/> c) Have you ever had chest pain during or after exercise?</p> <p><input type="checkbox"/> d) Do you get tired more quickly than your teammates do during exercise?</p> <p><input type="checkbox"/> e) Have you ever had discomfort, pain, or pressure in your chest during exercise?</p> <p><input type="checkbox"/> f) Have you ever had racing of your heart or skipped heartbeats?</p> <p><input type="checkbox"/> 8. Has your doctor ever told you that you have:
 <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol
 <input type="checkbox"/> Low blood pressure <input type="checkbox"/> A heart murmur</p> <p><input type="checkbox"/> 9. Have you had a severe heart infection (ex: myocarditis or pericarditis)?</p> <p><input type="checkbox"/> 10. a) Has any family member or relative died of heart problems or sudden death before age 50?</p> <p><input type="checkbox"/> b) Has any family member been diagnosed with: enlarged heart, cardiomyopathy, Marfan's Syndrome, long QT interval, abnormal EKG, or abnormal heart rhythm?</p> |
|--|--|

NOTE: All portions of Medical History and all consent forms must be completed prior to physical examination.
 : The medical consent & information disclosure form, which must be signed by the student-athlete (and a parent, if the student is under 18 y.o.), is located on a separate sheet.

Student

Name _____ SSN _____
Last First Middle Initial

General, continued

- | | |
|--|--|
| <p><input type="checkbox"/> 11. a) Have you ever seen a cardiologist (heart specialist)? If yes, when? _____</p> <p><input type="checkbox"/> b) Have you ever had an EKG or echocardiogram?</p> <p><input type="checkbox"/> c) Has a doctor ever ordered any other test(s) for your heart?</p> <p><input type="checkbox"/> 12. Has any relative suddenly died at 40 y.o. or younger of causes other than an accident? If yes, provide age & explain below.</p> <p><input type="checkbox"/> 13. Has a physician ever denied or restricted your participation in sports for any heart problem?</p> <p><input type="checkbox"/> 14. a) Were you born without or are you missing any paired organ (ex: eye, lung, kidney, ovary) or other organ?</p> <p><input type="checkbox"/> b) Do you have seriously impaired function of any organ?</p> <p><input type="checkbox"/> 15. Have you ever had anemia?</p> <p><input type="checkbox"/> 16. Have you or a relative ever had:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Cancer <input type="checkbox"/> Lung disease <input type="checkbox"/> Sickle cell disease</p> <p style="margin-left: 20px;"><input type="checkbox"/> Stroke <input type="checkbox"/> Blood disease</p> <p><input type="checkbox"/> 17. Have you ever had kidney disease or a urinary infection?</p> <p><input type="checkbox"/> 18. Have you ever had a hernia or appendicitis?</p> | <p><input type="checkbox"/> 20. Do you have any other acquired or inherited diseases (ex: Lyme disease, hemophilia etc.)?</p> <p><input type="checkbox"/> 21. Have you had a severe viral infection within the last year (ex: mononucleosis, cytomegalovirus)?</p> <p><input type="checkbox"/> 22. Have you ever had any chronic stomach, gastrointestinal, or bowel problems?</p> <p><input type="checkbox"/> 23. a) Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus, blisters)?</p> <p><input type="checkbox"/> b) Have you ever had a herpes skin infection?</p> <p><input type="checkbox"/> 24. When exercising in the heat, do you have severe muscle cramps or become ill?</p> <p><input type="checkbox"/> 25. a) Do you cough, wheeze, or have trouble breathing during or after activity?</p> <p><input type="checkbox"/> b) Do you have seasonal allergies that require medical treatment?</p> <p><input type="checkbox"/> c) Does anyone in your family have asthma? If yes, specify below.</p> <p><input type="checkbox"/> d) Have you ever used or currently use an inhaler or asthma medication?</p> <p><input type="checkbox"/> e) Do you currently have asthma?</p> |
|--|--|

Explain Yes answers: _____

Head and Neck

- | | |
|---|---|
| <p><input type="checkbox"/> 26. a) Have you ever been hit in the head or face and experienced confusion afterward?</p> <p><input type="checkbox"/> b) Have you ever been knocked out, become unconscious or lost your memory?</p> <p><input type="checkbox"/> c) Have you ever had a: <input type="checkbox"/> head injury or <input type="checkbox"/> a concussion?</p> <p style="margin-left: 20px;">i. If yes, how many times? _____</p> <p><input type="checkbox"/> ii. Did you miss any practice or playing time? Explain below.</p> <p style="margin-left: 20px;">iii. What was the severity of each one (ex: 1st degree-mild, 2nd degree-moderate, 3rd degree-severe)? Explain below.</p> <p style="margin-left: 20px;">iv. When was the last concussion? _____</p> <p><input type="checkbox"/> v. Were you cleared by a physician to resume athletic activity following your head injury or concussion(s)?</p> <p><input type="checkbox"/> 27. Have you ever had a CT scan, MRI, or any other type of brain/head scan following a head, face, or neck injury?</p> | <p><input type="checkbox"/> 28. Have you ever been hospitalized for a head, face, or neck injury?</p> <p><input type="checkbox"/> 29. a) Have you ever had a seizure?</p> <p><input type="checkbox"/> b) Do you have epilepsy?</p> <p><input type="checkbox"/> 30. Do you have frequent or severe headaches?</p> <p><input type="checkbox"/> a) Have you ever had numbness or tingling in your arms, hands, legs, or feet after being hit or falling?</p> <p><input type="checkbox"/> b) Have you ever been unable to move your arms or legs after being hit or falling?</p> <p><input type="checkbox"/> 32. Have you ever had a "stinger," "burner," or a pinched nerve?</p> <p><input type="checkbox"/> If yes to # 32, have you completed physical therapy for this problem?</p> <p><input type="checkbox"/> 33. Do you visit a chiropractor regularly for this <i>or any other</i> problem?</p> |
|---|---|

Explain Yes answers: _____

Student

Name _____ SSN _____ - _____ - _____
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Nose

- | | |
|--|--|
| <input type="checkbox"/> 40. a) Do you have frequent nosebleeds?
<input type="checkbox"/> b) Have you ever had a broken/fractured nose? | <input type="checkbox"/> c) Do you have problems with nasal blockage?
<input type="checkbox"/> d) Do you experience significant sinus problems? |
|--|--|

Explain Yes answers: _____

Dental

- | | |
|---|---|
| <input type="checkbox"/> 41. Do you wear orthodontic braces?
<input type="checkbox"/> 42. Do you have any false teeth, bridges, or plates? If yes, do you wear them during athletic activity? _____
<input type="checkbox"/> 43. a) Have you ever been instructed by a physician or other medical professional to wear a mouth guard? | <input type="checkbox"/> b) Do you wear a mouth guard?
<input type="checkbox"/> 44. Do you have regular, bi-annual dental exams? If yes, provide date of last exam _____ |
|---|---|

Explain Yes answers: _____

Vision

- | | |
|---|--|
| <input type="checkbox"/> 45. a) Have you ever had any problems with your eyes or vision?
<input type="checkbox"/> b) Have you ever had an eye injury or infection?
<input type="checkbox"/> c) Do you or any relatives have glaucoma? Explain below.
<input type="checkbox"/> 46. a) Do you have any visual impairment?
<input type="checkbox"/> b) Do you wear glasses or contacts?
i. Which do you wear during play? _____ | <input type="checkbox"/> 47. a) Have you ever been instructed by a physician or other medical professional to wear protective eye gear such as goggles or a face shield?
<input type="checkbox"/> b) Do you wear protective eye gear such as goggles or a face shield?
<input type="checkbox"/> 48. Do you have regular, annual eye exams? If yes, provide date of last exam _____ |
|---|--|

Explain Yes answers: _____

Nutritional Profile

- | | |
|---|---|
| <input type="checkbox"/> 49. Do you currently use or have you ever used <i>any</i> of the following. For yes answers, please explain details & provide dates if possible.
<input type="checkbox"/> Tobacco: smokeless, cigarettes <input type="checkbox"/> MET-Rx
<input type="checkbox"/> Ergogenic aids <input type="checkbox"/> "Recreational" drugs
<input type="checkbox"/> Steroids (any form) <input type="checkbox"/> Androstenedione, or similar substances
<input type="checkbox"/> Weight loss supplements <input type="checkbox"/> Ephedra or Ma Huang
<input type="checkbox"/> Herbal supplements <input type="checkbox"/> Caffeine (provide products/typical daily intake)
<input type="checkbox"/> GNC products
<input type="checkbox"/> Creatine | <input type="checkbox"/> 50. a) Do you lose weight regularly to meet weight expectations for your sport?
i. Do you want to weigh more or less than you do now? _____
ii. How many diets have you been on in the past year? _____
<input type="checkbox"/> b) Do you think you should be dieting now?
<input type="checkbox"/> c) Are you dissatisfied with your body size?
<input type="checkbox"/> d) Does your weight affect the way you think about yourself? |
|---|---|

Explain Yes answers: _____

Other

51. Do you have any other medical condition or abnormality, which has not been addressed on this form?
 52. Have you had any other injuries, procedures, or surgeries, which have not been addressed on this form?
 53. Are you currently under the care of/being treated by a physician for any other injury or condition not already explained on this form?
 54. Do you have any questions or concerns that you would like to discuss with a doctor?

Explain Yes answers: _____

Midway College Student-Athlete Pre-participation Medical History / Sport Physical Form

Student

Name _____ SSN _____ - _____ - _____
Last First Middle Initial

Vitals (completed by Medical Staff only)

Height _____' _____" Weight _____ lbs BMI _____ Optional: % Body fat: 1) Calipers _____ 2) Bio impedance _____
 BP _____ / _____ Pulse _____ Concussion baseline testing: BESS _____
 Vision: Use glasses or contacts? Y N Pupils: Equal Unequal SAC _____/30
 Wearing for exam? Y N R 20/____ L 20/_____

Examination (completed by Medical Staff only)

MUSCULOSKELETAL	Normal	Abnormal / Recommendations	Initials*
Neck			
Back / Spine			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Core strength			
Balance			

MEDICAL	Normal	Abnormal	Initials*
Eyes			
Ears, Nose, Throat			
Lymph nodes			
Heart : Supine			
: Standing			
Pulses			
Lungs			
Abdomen			
Skin			
Other			

*Station-based examination only

Clearance (completed by Medical Staff only)

I certify that I have on this date reviewed the student's medical history as furnished to me, examined the above student, and recommend (please make any recommendations or notations below):

- Student is **approved** for full sport participation with **no limitations**
- Student is **approved pending** additional information and/or **tests**.
Once completed & reviewed, student is approved for full participation
- Student is **referred** to other health care professional **prior to clearance**
Once completed & reviewed, student is approved for full participation
- Student is **approved** for participation **with limitations**
- Student is **not approved** for participation

Recommendations:

Flexibility training Strengthening Equipment Medical referral
 Psychological counseling Nutritional counseling Drug counseling

Physician Signature _____ Date _____

If physical not conducted by Midway College team physicians, please provide printed physician name & office stamp: _____

Student

Name _____ SSN _____
Last First Middle Initial

The undersigned athlete, hereafter:

- Understands participation in sport requires an acceptance of risk of injury and the responsibility for sport safety must be shared by all. Included in this group are administrators, coaches, physicians, athletic trainers and student-athletes. I, the undersigned, am aware that there is a certain risk of injury involved in my participation in intercollegiate athletics at Midway College. I understand that my signature does not relieve the college of responsibilities to me. By signing below I acknowledge that I am responsible for preventing potential injuries, complying with the treatment plan of the Midway College Sports Medicine Team, and that there is risk of injury. I understand that this includes the risk of spinal cord and brain injury that may result in paralysis and the possibility of other permanent injury or death. I acknowledge the facts that these risks exist and I am willing to assume responsibility for such risks while participating in athletics at Midway College.
- Understands that Midway College requires all athletes to show proof of immunizations (ex: hepatitis, MMR, polio, TB skin test, etc.). By signing below I attest that *my immunization records are complete, current, and on file with the campus nurse as of this date* (written below).
- Understands this physical is for no other purpose than to clear me for athletic participation at Midway College. I understand it is not a physical examination for health matters that may develop in the future.
- I understand that the team physicians and/ or the athletic trainer have the authority to eliminate me from further participation because of an injury, illness, and/or an undue risk to Midway College.
- Understands that any medical expense incurred due to the pre-existing condition(s) on this form or not directly attributable to athletic participation at Midway College is my personal responsibility.
- Understands the sports medicine program and secondary payment for athletic-related injury at Midway College.
- Understands that the periodic analyses of injury patterns lead to refinements in the rules and other safety decisions. However, legislating safety via a rule book and equipment standards, while often necessary, seldom is effective by itself. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.
- Understands that she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until she is discharged from treatment or is given permission by her clinical practitioner to resume an appropriate level of participation despite continuing treatment.
- Understands that having passed the physical examination does not necessarily mean that she is physically qualified to engage in athletics, but only that the evaluator(s) did not find any medical reason to disqualify her at the time of the preparticipation examination.

STOP! – I hereby state that the information contained in this pre-participation physical examination form is truthful, correct, and has been completed to the best of my knowledge.

I understand that any medical information withheld, incorrect, or incomplete may result in incorrect or incomplete medical treatment and may disqualify me from participation. I also understand that voluntary withholding of medical information will void any potential for secondary payment by Midway College.

I have not withheld any information about any physical problems in order to participate.

Athlete's Signature _____ Date _____

Parent's Signature _____ Date _____
(If athlete is under 18 years old)