

Midway College

Returning Student-Athlete Medical History Update / 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 _____ Relationship _____

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

Medical History Update

This section is to be carefully completed by the student 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 space following this section or to provide any other information. Circle questions if you don't know the answer.

Since your last pre-participation sport physical, has there been a change in your medical condition or history?

- | | |
|--|--|
| <p><input type="checkbox"/> 1. Have you had a significant medical illness or injury since your last checkup or sports physical?</p> <p><input type="checkbox"/> 2. Have you had any surgeries in the last year?</p> <p><input type="checkbox"/> 3. Any auto or other accidents that required medical attention/hospitalization?</p> <p><input type="checkbox"/> 4. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills?</p> <p><input type="checkbox"/> 5. Do you have any allergies (ex: medicine, stinging insects, food, or environmental [pollen, dust, etc.]?)? Epipen (epinephrine) needed? Y N</p> <p><input type="checkbox"/> 6. Have any family members experienced any new conditions or diseases?</p> <p><input type="checkbox"/> 7. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?</p> <p><input type="checkbox"/> 8. Have you had any fainting or dizzy spells or periods of unconsciousness?</p> <p><input type="checkbox"/> 9. Do you experience shortness of breath, cough, wheeze, or have trouble breathing during or after activity? Inhaler needed? Y N</p> | <p><input type="checkbox"/> 10. Have you experienced any abdominal/stomach problems?</p> <p><input type="checkbox"/> 11. Have you experienced any emotional or stress problems?</p> <p><input type="checkbox"/> 12. Have you had any (please circle) head injuries or concussions in the last year? If yes, how many? _____ Severity & dates(s) _____</p> <p><input type="checkbox"/> 13. Any injuries requiring bracing, rehabilitation, or physician evaluation?</p> <p><input type="checkbox"/> 14. Have you experienced any menstrual problems or disorders?</p> <p><input type="checkbox"/> 15. Are you wearing any dental appliances, hearing aids, glasses or contacts?</p> <p><input type="checkbox"/> 16. Are you taking any nutritional supplements to help you lose or gain weight, or to improve your athletic performance?</p> <p><input type="checkbox"/> 17. Have you started or stopped smoking?</p> <p><input type="checkbox"/> 18. Are you currently under a doctor's care for any reason?</p> <p><input type="checkbox"/> 19. Has the Head Athletic Trainer or a physician denied or recommended against your further participation in a sport or activity?</p> |
|--|--|

STOP! I attest that the above information is correct and complete to the best of my knowledge. I understand that any medical information withheld, incorrect, or incomplete may result in incomplete or incorrect medical treatment and may disqualify me from participation. I also understand that voluntary withholding of medical information will void any potential secondary payment by Midway College. **I have not withheld any information about any physical problems in order to participate.**

Athlete signature _____ Date _____

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 _____
 Vision: Use glasses or contacts? Y N Pupils: Equal Unequal Concussion baseline testing: BESS _____
 Wearing for exam? Y N R 20/_____/_____/ L 20/_____/_____/ SAC _____/30

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: _____