COLLEGE OF LAKE COUNTY
PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Name:  Last  First  MI  1st or 2nd yr.  Sex:  M / F  DOB  

Address: ____________________________________ Phone/Cell: ____________________________

City___________________________________________ State_____ Zip________

Emergency Contact:______________________ Phone/Cell_____________________ Relationship_________________

Sport(s) in which you intend to participate in: ________________________________________________

SECTION I -  Medical History
Please check any of the following that apply to you (past or present):

___ Allergic or sensitive to:  ___ Concussion  ___ Kidney/Bladder infections
___ Medication   ___ Diabetes   ___ Mononucleosis
___ Food    ___ Ear/Nose/Throat  ___ Nervous condition
___ Inhalants   ___ Vision Problems  ___ Recurring headaches
___ Insect bites   ___ Color Blindness  ___ Respiratory problems
___ Adhesive tape   ___ Contact Lenses  ___ Asthma
___ Other   ___ Heart Disease/Dizziness  ___ Pneumonia
___ Anorexia   ___ Hepatitis   ___ Rheumatic fever
___ Bulimia   ___ Hernia   ___ Seizure disorders
___ Bleeding disorder   ___ High blood pressure  ___ Stomach problems
___ Cancer   ___ Low blood pressure  ___ Tuberculosis (TB)
___ Fractures

Explain, all checks above:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Please list and date any operations, injuries, fractures, sprains, or significant illnesses in your past history:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Do you have any condition other than those listed that requires continuing treatment?
______Yes _______No   If yes, explain: ____________________________________________________

List any medications you take regularly: _____________________________________________________

Most recent dental exam: ___________________________________________________________________
Dentist name: _____________________________ Phone: _________________________________

Have you ever been advised against normal physical exercise? _____ Yes     _____ No
If yes, give date and reason: __________________________________________________________

Have you ever been treated for back or neck problems? _____ Yes     _____ No
If yes, give name of doctor, specific problem, & date of treatment ____________________________

Other muscular-skeletal problems? _____ Yes     _____ No

Do you have difficulty hearing or understanding what others say? _____ Yes     _____ No

Have you experienced a weight gain/loss during the past year? _____ Yes     _____ No
How much? _____ Gain   _____ Loss

Dates of immunizations:
Tetanus _______  Measles, mumps, rubella_______  Polio_____  Other_____

Significant family medical history:
Has anyone in your family, under 50 died suddenly & unexpectedly? ___ Yes ___ No
At what age?   __________  Cause of death? ________________________________________________

Any recent foreign travel? _______________________________________________________________
## SECTION II – Physical Examination

(MUST BE COMPLETED BY A LICENSED MEDICAL PHYSICIAN, OSTEOPATHIC PHYSICIAN OR PHYSICIAN’S ASSISANT).

### Physical Findings:
- B/P _______
- Height _______
- Vision R _______ L _______
- Pulse _______
- Weight _______
- Hearing R _______ L _______

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<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. General appearance</td>
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<td>2. Head</td>
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<td>3. Vision Exam</td>
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<td>4. Hearing Exam</td>
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<td>5. Nose, throat, &amp; dental</td>
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<td>6. Respiratory/lungs/chest</td>
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<td>7. Cardiovascular</td>
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<td>8. Lymphatic’s</td>
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<td>9. Gastrointestinal</td>
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<td>10. Gentiourinary/hernia/testicles</td>
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<td>11. Neurological</td>
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<td>12. Psychological</td>
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<td>13. Skin/Scars</td>
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<td>14. Muscular/skeletal/ROM</td>
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**Laboratory Test**

- U/A ____________________
- Blood Test ______________

Specify any restrictions regarding this athlete’s activity:
____________________________________________________________________________________________
____________________________________________________________________________________________

Is this person presently under any medical/psychological therapy? 
- Yes
- No

If yes, please explain:
____________________________________________________________________________________________
____________________________________________________________________________________________

Other remarks and/or recommendations for health maintenance or improvement:
____________________________________________________________________________________________
____________________________________________________________________________________________

**PLEASE TYPE OR PRINT:**

Physicians Name ___________________________ Date of Exam _______________
Office address _____________________________
Fax ________________________________ Phone ___________________________

**Physician’s Signature:** ____________________________________________________________________

I authorize and give my consent for assessment, nursing diagnosis and treatment as deemed necessary by the employees of the College of Lake County. For anyone under 18, written consent from parent or legal guardian required before treatment.

Athlete’s Signature ___________________________ Date ___________________________