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

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 PHYSICAN OR PHYSICAN'S ASSISANT).**

Physical Findings: B/P _____ Height _____ Vision R _____ L _____
Pulse _____ Weight _____ Hearing R _____ L _____

	Normal	Abnormal	Comments

1. **General appearance** _____
2. **Head** _____
3. **Vision Exam** _____
4. **Hearing Exam** _____
5. **Nose, throat, & dental** _____
6. **Respiratory/lungs/chest** _____
7. **Cardiovascular** _____
8. **Lymphatic's** _____
9. **Gastrointestinal** _____
10. **Gentiourinary/hernia/testicles** _____
11. **Neurological** _____
12. **Psychological** _____
13. **Skin/Scars** _____
14. **Muscular/skeletal/ROM** _____

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**