

ATHLETIC PHYSICAL EXAM

===== TO BE COMPLETED BY THE STUDENT-ATHLETE =====

Name: _____

Sport(s): _____ Year in School: Fr So Jr Sr 5th

Date of Birth: _____ / _____ / _____ Social Security Number: _____
MONTH DAY YEAR

===== HEALTH QUESTIONNAIRE =====

Date of Last Physical Examination: _____ / _____ / _____
MONTH DAY YEAR

The following questions MUST have current answers by the athletes. If checked YES, please provide detailed comments:

1. Have you ever been hospitalized or had a major illness since the age of 12 years? Y N

Description: _____

2. Have you ever had a major injury (including cerebral concussion and surgery) since the age of 12 years? Y N

Description: _____

3. Do you currently have any incompletely healed injury? Y N

Description: _____

4. In the past 6 months, have you had any medical condition that required you to see a Health Care Professional (physician, PT, athletic trainer, chiropractor)? Y N

Description: _____

5. Are you currently ill in any way? Y N

Description: _____

6. Have you ever had an operation (If yes, specify and give dates) Y N

Description: _____

7. Have you ever been advised to have a surgical procedure which was not done? Y N

Description: _____

8. Are you taking any medications on a regular basis? Y N

If yes, Name of Drug _____ Reason _____ Dosage _____

9. Do you know of, or believe there is, any health reason why you should not participate in Santa Clara University's intercollegiate athletics program at this time? Y N

I hereby certify that to the best of my knowledge, my answers to the above questions are accurate and complete

 SIGNATURE OF STUDENT-ATHLETE

 DATE

 REVIEWED BY: SIGNATURE OF ATHLETIC TRAINER

 DATE

SEND COMPLETED FORM TO: Santa Clara University Attn: Sports Medicine Center Athletic Department Santa Clara, CA. 95053

ATHLETIC PHYSICAL EXAM

===== TO BE COMPLETED BY S.O.A.R. PHYSICIAN AND STAFF =====

Name: _____ Age: _____ Year in School: Fr So Jr Sr 5th

Height (in): _____

Visual Acuity: R.....20 / _____

Weight (lbs): _____

L.....20 / _____

Pulse Rate: _____

uncorrected glasses contacts

Blood Pressure: _____

Hearing: R.....normal _____

Temperature: _____

.....decreased _____

L.....normal _____

.....decreased _____

(Using Finger Rub Test)

===== TO BE COMPLETED BY PHYSICIAN =====

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Eyes	_____	_____	Musculoskeletal	_____	_____
Ears	_____	_____	Neurological	_____	_____
Respiratory	_____	_____	Lymph Nodes	_____	_____
Cardiovascular	_____	_____	Skin	_____	_____
Abdomen	_____	_____	Heart (Marfans)	_____	_____

Please list any health concerns for the athlete

- _____
- _____
- _____
- _____

Recommendations/Limitations/Medications Prescribed

- _____
- _____
- _____
- _____

I certify that I have examined _____ on _____ and that on the basis of the medical history supplied to me and my examination, I have found no reason which would make it medically inadvisable for this student to participate in athletic activities, EXCEPT those noted above.

SIGNATURE OF PHYSICIAN

DATE