

ONONDAGA COMMUNITY COLLEGE ATHLETICS HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

(Please fill this out in pen and take time to carefully read this and fill it out as accurately as possible. If you are not sure of a question, please ask your parent/guardian or the certified athletic trainer on staff for help.)

Name:	Academic Year:	Sport:	Birth Date:	Age:
Social Security # or Student ID #:	Year: (circle one) FR SO			
Parent/Guardian Name(s):	Campus/Local Address (if different from permanent address):			
Permanent Address:	City/State/Zip:			
City/State/Zip:	Local Phone:			
Home Phone:	Athlete's Cell Phone:			
Emergency Contact Information (Name, relationship to you, and numbers they can be reached at):				
E-mail Address:				

Please circle Yes (Y) or No (N) for each question (If you answer 'Yes' to a question, please provide a detailed explanation)

1. Has a doctor ever denied or restricted your participation in sport for any reason? **Y/N**

2. Do you see a doctor on a regular basis for a medical condition (i.e. epilepsy, seizures)? **Y/N**

3. Do you wish to see a doctor for a current health problem or injury? **Y/N**

4. Have you ever been treated or informed by a physician that you have diabetes? **Y/N** _____
5. Do you have asthma? **Y/N** Please indicate medication(s) used. _____
6. Have you been diagnosed with a heart murmur? **Y/N**

7. Are you presently taking any medication(s)? **Y/N** _____
8. Do you have any allergies to medicine, foods, or insect bites/stings? **Y/N** _____

If so, what are the signs or symptoms of an allergic reaction: _____
9. Have you ever had heat cramps, heat stroke, or do you have sensitivity to the cold? **Y/N**

10. Have you ever experienced any of the following during exercise: chest pain; difficulty breathing, coughing or keeping up; dizziness; passing out; an irregular heartbeat; or elevated blood pressure? **Y/N**

11. Have you ever experienced any fainting spells, headaches, blackouts, concussions, or been “knocked out”? **Y/N**

12. Do you have eye or vision troubles? **Y/N** If so, do you wear eye glasses or contact lenses? **Y/N**

13. Do any of your family members have a blood disorder (i.e. Sickle Cell Anemia)? **Y/N**

14. Has any family member been diagnosed with heart disease, or died suddenly, before the age of 50 due to heart disease or a heart problem? **Y/N**

15. Have you ever been hospitalized for any condition or major illness? **Y/N** _____

16. Have you ever had a non-orthopedic surgery (wisdom teeth, appendix, hernia, etc)? **Y/N** _____

17. Have you sustained any injuries (e.g. sprain, strain, fracture, dislocation, concussion) to the following areas?

Head	YES	NO	Neck	YES	NO	Shoulder	YES	NO	Elbow	YES	NO
Wrist	YES	NO	Hand/Finger	YES	NO	Back	YES	NO	Hip	YES	NO
Thigh	YES	NO	Knee	YES	NO	Calf/Shin	YES	NO	Ankle	YES	NO
Foot	YES	NO									

If yes, please explain

18. Have you received orthopedic surgery for any of the above bone or joint injuries? **Y/N** _____

19. Have you fully recovered from and are you back to full participation for any injury listed? **Y/N**

20. **FEMALES ONLY:** How many periods have you had in the last 12 months? _____

Additional Comments:

I verify that all the above information is accurate and complete. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct and that failure to disclose previous medical conditions may result in my removal from the team. I understand that the Onondaga Community College Athletics Department **is not** responsible for expenses related to pre-existing conditions.

Signature of Athlete: _____ Date: _____

Sports Physical Examination Form

VITALS EXAMINATION (To ONLY be filled out by person qualified to perform sports physical.)			
Athletes Name:	Height:		
	Weight:		
Eyes: Are corrective glasses or contacts worn during participation:		YES	NO
Left: 20/	Corrective Left:	20/	
Right: 20/	Corrective Right:	20/	
Blood pressure:	Pulse:		

HEENT: _____

LUNGS: _____

HEART: _____

ABDOMEN: _____

SPINE: _____

ORTHOPEDIC: _____

HERNIA/GENT: _____

PHYSICIAN COMMENTS: _____

MEDICAL STATUS: [CLEARED] [CLEARED WITH RESTRICTIONS] [FAILED]
Examining Physician: _____ Date: _____

