

Physical Examination Record

Required for Student Athletes Only

THIS SIDE TO BE COMPLETED BY STUDENT OR STUDENT'S PARENT OR GUARDIAN.

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

The physical exam must take place **after June 1, 2017**, in order to remain valid throughout the 2017-18 athletic seasons.

Male Female Spring Fall Year 20 _____

Name _____ **Soc. Sec. Number** _____
First M. Last

Address _____
Street City State ZIP

Date of Birth _____ **Age** _____ **Cell Phone** _____

Sport(s) _____

IN AN EMERGENCY, CONTACT:

Name _____ **Relationship** _____

Address _____
Street City State ZIP

HomePhone _____ **WorkPhone** _____ **CellPhone** _____

Name and Address of Family Physician _____

If student is not yet 19 years of age, this side must be completed by a parent or guardian before a physical examination can be given.

MEDICAL HISTORY

- | | |
|--|---|
| <small>Yes No</small> | <small>Yes No</small> |
| <input type="radio"/> <input type="radio"/> Asthma | <input type="radio"/> <input type="radio"/> Shortness of breath with activity |
| <input type="radio"/> <input type="radio"/> Diabetes | <input type="radio"/> <input type="radio"/> Cardiac/Heart Problems |
| <input type="radio"/> <input type="radio"/> Mononucleosis | <input type="radio"/> <input type="radio"/> Tuberculosis |
| <input type="radio"/> <input type="radio"/> Hepatitis | <input type="radio"/> <input type="radio"/> Sickle Cell |
| <input type="radio"/> <input type="radio"/> Epilepsy/Seizures | <input type="radio"/> <input type="radio"/> Hernia |
| <input type="radio"/> <input type="radio"/> High Blood Pressure | <input type="radio"/> <input type="radio"/> HIV/AIDS |
| <input type="radio"/> <input type="radio"/> Kidney Disease | <input type="radio"/> <input type="radio"/> Others |
| <input type="radio"/> <input type="radio"/> Bleeding Disorder | |
| <input type="radio"/> <input type="radio"/> Disordered Eating | |
| <input type="radio"/> <input type="radio"/> Chronic Skin Disorders | |

Please explain any "yes" answers to the diseases noted above (dates/current condition/etc.):

Current medications:

Limitations/restrictions:

Food/medication/sting/bite or other known allergies:

ORTHOPEDIC HISTORY

- | | | |
|---|---|--|
| <i>General</i> | <i>Specific</i> | <small>Yes No</small> |
| <small>Yes No</small> | <small>Yes No</small> | <small>Yes No</small> |
| <input type="radio"/> <input type="radio"/> Sprains | <input type="radio"/> <input type="radio"/> Skull | <input type="radio"/> <input type="radio"/> Abdominal |
| <input type="radio"/> <input type="radio"/> Strains | <input type="radio"/> <input type="radio"/> Fracture | <input type="radio"/> <input type="radio"/> Chest & Ribs |
| <input type="radio"/> <input type="radio"/> Fractures | <input type="radio"/> <input type="radio"/> Concussions | <input type="radio"/> <input type="radio"/> Foot |
| <input type="radio"/> <input type="radio"/> Subluxations | <input type="radio"/> <input type="radio"/> # _____ | <input type="radio"/> <input type="radio"/> Ankle |
| <input type="radio"/> <input type="radio"/> Ligament Injuries | <input type="radio"/> <input type="radio"/> Face Injury | <input type="radio"/> <input type="radio"/> Knee |
| <input type="radio"/> <input type="radio"/> Dislocations | <input type="radio"/> <input type="radio"/> Eye | <input type="radio"/> <input type="radio"/> Upper leg |
| | <input type="radio"/> <input type="radio"/> Ear | <input type="radio"/> <input type="radio"/> Lower leg |
| | <input type="radio"/> <input type="radio"/> Nose | <input type="radio"/> <input type="radio"/> Hip |
| | <input type="radio"/> <input type="radio"/> Spine | <input type="radio"/> <input type="radio"/> Pelvis |
| | <input type="radio"/> <input type="radio"/> Neck | <input type="radio"/> <input type="radio"/> Hand |
| | <input type="radio"/> <input type="radio"/> Lower back | <input type="radio"/> <input type="radio"/> Wrist |
| | | <input type="radio"/> <input type="radio"/> Forearm |
| | | <input type="radio"/> <input type="radio"/> Elbow |
| | | <input type="radio"/> <input type="radio"/> Upper arm |
| | | <input type="radio"/> <input type="radio"/> Shoulder |

Description (body part/side/specific injury/date/current condition/etc.):

Surgical procedure (body part/side/date/current condition/etc.):

Any other current or severe injury not already listed?

This side was completed by _____

PRINTED NAME

SIGNATURE

DATE

ATHLETE NAME: _____

THIS SIDE TO BE COMPLETED BY A PHYSICIAN.

Physical Examination

Weight _____ Height _____ Nose _____
Eye: Os _____ Os _____ Neck _____
Thorax (deformity) _____ Auscultation _____
Heart Pulse _____ Blood Pressure _____ Blood Type _____
Lungs _____ Hernia _____
Abdomen (scars, masses, etc.) _____ Rectum _____
_____ Lower Extremities (range of motion, alignment, scars) _____
Ears: Right _____ Left _____

Neurological Screening

Right _____ BJ TJ KJ KJ Finger-nose Babinski
Left _____

Heart Health Questions About You

- 1. Have you ever passed out or nearly passed out during exercise? Yes No
- 2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
- 3. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)

Heart Health Questions About Your Family

- 1. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? Yes No
- 2. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
- 3. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
- 4. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

Participation Status

- Full participation
- Limited participation (explain below)
- No participation

Please indicate which sports (if any) this person should not participate in: _____

Comments: _____

Physician who administered this examination (must be an MD, DO, PA-C, or APRN)

- Medical Doctor
- Doctor of Osteopathy
- Physician Assistant
- Advanced Practice Registered Nurse

Physician Name (please print) _____

Physician Address _____
Street City State ZIP

SIGNATURE OF PHYSICIAN

DATE

PLEASE RETURN TO:
800 N. Columbia Ave.
Seward, Nebraska 68434
Attn: Athletics