FOR STUDENT ATHLETES ONLY COMPLETE AND RETURN AFTER JUNE 1, 2020

2020-21 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, 2020**, in order to remain valid throughout the 2020-21 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

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

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

Yes	No		Yes	No	
○	○	Asthma	○	○	Shortness of breath with activity
○	○	Diabetes	○	○	Cardiac/Heart Problems
○	○	Mononucleosis	○	○	Tuberculosis
○	○	Hepatitis	○	○	Sickle Cell
○	○	Epilepsy	○	○	Hernia
○	○	High Blood Pressure	○	○	HIV/AIDS
○	○	Kidney Disease	○	○	Others
○	○	Bleeding Disorder			
○	○	Disordered Eating			
○	○	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

General

Yes	No	
○	○	Sprains
○	○	Strains
○	○	Fractures
○	○	Subluxations
○	○	Ligament Injuries
○	○	Dislocations

Specific

Yes	No		Yes	No	
○	○	Skull	○	○	Abdominal
	○	Fracture	○	○	Chest & Ribs
○	○	Concussions	○	○	Foot
	○	# _____	○	○	Ankle
○	○	Face Injury	○	○	Knee
	○	Eye	○	○	Upper leg
	○	Ear	○	○	Lower leg
	○	Nose	○	○	Hip
○	○	Spine	○	○	Pelvis
	○	Neck	○	○	Hand
	○	Lower back	○	○	Wrist
			○	○	Forearm
			○	○	Elbow
			○	○	Upper arm
			○	○	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: _____ **SPORT:** _____

THIS SIDE TO BE COMPLETED BY A PHYSICIAN.

Physical Examination

Weight _____ Height _____
Eye: Os _____ Os _____
Thorax (deformity)_____
Heart Pulse _____ Blood Pressure _____
Lungs _____
Abdomen (scars, masses, etc.) _____
_____
Ears: Right _____ Left _____

Nose _____
Neck _____
Auscultation _____
Blood Type _____
Hernia _____
Lower Extremities (range of motion, alignment, scars) _____
_____
_____

Neurological Screening

	BJ	TJ	KJ	KJ	Finger-nose	Babinski
Right						
Left						

Heart Health Questions About You

	Yes	No
1. Have you ever passed out or nearly passed out during exercise?	○	○
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

	Yes	No
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)?	○	○
2. Does anyone in your family have hypertrophic cardiomypathy, Marfan syndrome, arrhythmogenic right vetricular 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 defibrilator?	○	○
4. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	○	○

If you answered yes to any questions above, please explain: _____

Participation Status

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

Please indicate which sports (if any) this person should not particpate 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: Admssions