2025-26 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, 2025**, in order to remain valid throughout the athletic seasons.

○ Returning Athlete ○ New Athlete ○ 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) _____ **Student ID J#** _____

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	○	○	Tuberculosis
○	○	Diabetes	○	○	Sickle Cell
○	○	Mononucleosis	○	○	Hernia
○	○	Hepatitis	○	○	COVID
○	○	Epilepsy			*If yes, Illness Date* _____
○	○	High Blood Pressure	○	○	COVID Vaccination
○	○	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		
○	○	Skull	
		○	Fracture
○	○	Concussions	
		○	# _____
○	○	Face Injury	
		○	Eye
		○	Ear
		○	Nose
○	○	Spine	
		○	Neck
		○	Lower back

Yes	No	
○	○	Abdominal
○	○	Chest & Ribs
○	○	Foot
○	○	Ankle
○	○	Knee
○	○	Upper leg
○	○	Lower leg
○	○	Hip
○	○	Pelvis
○	○	Hand
○	○	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**

Please upload to your student health portal on cune.studenthealthportal.com.

PHYSICAL FORM FOR STUDENT ATHLETES

ATHLETE NAME: _____ **SPORT:** _____

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: _____

Patient Health Questionnaire

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

THIS SECTION TO BE COMPLETED BY A MEDICAL PROVIDER.

Eye Examination

Eye: RT _____ LT _____ Contacts _____ Glasses _____ Last Eye Exam _____

Physical Examination

Weight _____ Height _____

BP _____/_____ T_____ P_____ O2 _____

Ears: Right _____ Left _____

Nose _____

Throat _____

Neck _____

Heart _____

Thorax (deformity) _____

Lungs _____

Abdomen _____

_____

Hernia _____

Upper/ Lower Extremities (range of motion, alignment, scars) ___

_____

GU _____

Skin _____

Neurological Screening

	Yes	No
Cranial Nerves 2-12 grossly intact?	○	○

Participation Status

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

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

Comments: _____

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

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

Medical Provider Name (please print) _____

Medical Provider Address _____
Street City State ZIP

_____

SIGNATURE OF MEDICAL PROVIDER **DATE**

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