Sports Participation Form

Student Name: ______________________________ Date: ____________________

Sport(s): ______________________________ Date of Birth: ____________________

Home Address: ____

I am a dorm student living in:

- ❑ Grant Hall (emergency contact: Nina Dewees: 267-502-2686)
- ❑ Childs Hall (emergency contact: Fredrik Bryntesson cell: 267-222-2164)
- ❑ Cottages (emergency contact: Cheryl Cooper: 267-502-2537)
- ❑ Residence Suites (emergency contact: Jennifer Lindsay: 267-502-2794)

EMERGENCY CONTACT INFORMATION		
Mother's Name	Father's Name	
Address: Street and Number		
City	State/Province	Zip/Postal Code
Telephone number at this address	Work phone	Cell phone
Alternate Contact (other than parents)	Home phone	Work or cell phone

INSURANCE INFORMATION		
Health Insurance Company Name	Group Number	ID Number
Address: Street and number		
City	State/Province	Zip/Postal Code
Primary physician's name (if you have an HMO)	Primary physician's phone number (if you have an HMO)	

Applicant's Signature ______________________ Date ____________

PLEASE REVIEW ALL QUESTIONS AND ANSWER THEM TO THE BEST OF YOUR KNOWLEDGE.	YES	NO	DON'T KNOW
1. Have you ever passed out during exercise or stopped exercising because of dizziness?	❑	❑	❑
2. Do you have asthma (wheezing), hay fever, or coughing spells after exercise?	❑	❑	❑
3. Have you ever broken a bone, had to wear a cast, or had an injury to any joint?	❑	❑	❑
4. Do you have a history of a concussion (getting knocked out)?	❑	❑	❑
5. Have you ever suffered a heat-related illness (heat stroke)?	❑	❑	❑
6. Do you have anything you want to discuss with the physician?	❑	❑	❑
7. Do you have any pre-existing medical conditions (diabetes, heart problems, etc.)?	❑	❑	❑
8. Do you take any medicine?	❑	❑	❑
9. Are you allergic to any medications or to bee stings?	❑	❑	❑
10. Do you have only one of any paired organ (eyes, ears, kidneys, etc.)?	❑	❑	❑

Sports Physical

PLEASE NOTE: **THIS SIDE FOR RETURNING STUDENTS ONLY.** NEW STUDENTS: YOUR SPORTS PHYSICAL IS PART OF YOUR MEDICAL FORM.

Must be completed and signed by personnel performing student's physical evaluation:

Name: ____________________ Enrolled in (school): ____________________

Sports: ____________________ Age: ____________________

Height: __________ Weight: __________ BP: ____/____ Pulse: ________ ❑ Right Handed (or) ❑ Left Handed

Parent/Guardian: ____________________ Phone: ____________________

Family Physician: ____________________ Phone: ____________________

Medical Examination

	NORMAL	ABNORMAL	IF "ABNORMAL" EXPLAIN
EENT	❑	❑	
Cardiovascular	❑	❑	
Cardiopulmonary	❑	❑	
Lungs	❑	❑	
Abdomen	❑	❑	
Genitourinary	❑	❑	
Neurological	❑	❑	
Skin	❑	❑	
Other	❑	❑	

Musculoskeletal Exam

	NORMAL	ABNORMAL	IF "ABNORMAL" EXPLAIN
Scoliosis	❑	❑	
Special Tests (based on history form)	❑	❑	
Neck	❑	❑	
Shoulder	❑	❑	
Elbow	❑	❑	
Wrist	❑	❑	
Hand	❑	❑	
Back	❑	❑	
Knee	❑	❑	
Ankle	❑	❑	
Foot	❑	❑	
Other	❑	❑	

Clearance for sports participation

Cleared for:

- ❑ Collision
- ❑ Contact
- ❑ Noncontact
- ❑ Strenuous
- ❑ Moderately Strenuous
- ❑ Nonstrenuous due to: ____________________

❑ Cleared after completing evaluation/ rehabilitation for: ____________________

Recommendation/referral: ____________________

Examiner name: ____________________

ADDRESS PHONE

SIGNATURE (MD/DO, PAC, CRNP, SNP) DATE