

Sports Participation Form

Student Name: _____ Date: _____

Sport(s): _____ Date of Birth: _____

Home Address: _____

I am a dorm student living in:

- Grant Hall (emergency contact: Edith van Zyverden cell: 215-962-3997)
- Childs Hall (emergency contact: Fredrik Bryntesson cell: 267-222-2164)
- Cottages (emergency contact: Kristin King: 267-502-2537)

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		ID Number
Address: Street and number		
City		State/Province
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have asthma (wheezing), hay fever, or coughing spells after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever broken a bone, had to wear a cast, or had an injury to any joint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of a concussion (getting knocked out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever suffered a heat-related illness (heat stroke)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have anything you want to discuss with the physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any pre-existing medical conditions (diabetes, heart problems, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you take any medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you allergic to any medications or to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have only one of any paired organ (eyes, ears, kidneys, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiopulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Musculoskeletal Exam

	NORMAL	ABNORMAL	IF "ABNORMAL" EXPLAIN
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Special Tests (based on history form)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hand	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____