

**Cornell College Athletics**  
**Preparticipation Physical Evaluation**

**ATHLETE INFORMATION FORM**

2009-2010

Cornell College Pre-Participation Physical Evaluation for ***FRESHMAN AND TRANSFER*** Student-Athletes.

This medical information must be completed and returned to Cornell College's Sports Medicine Department.

All **fall** athletes (other sports refer to the checklist) must have this form and the medical history form completed and turned in by ***Friday/ July 31, 2009*** before they will be allowed to participate/practice in any athletics at Cornell College.

Printed Name: _____	Year: FR SO JR SR	Gender: Male Female
Date of Birth: ___/___/___	Social Security Number: _____	
Sports Participating in at Cornell: _____		
Athlete's Cell Phone Number: _____		
<b>College Address (mailbox #) and Phone Number:</b>	<b>Home Mailing Address and Phone Number:</b>	

<b>Emergency Contacts: <i>*Two of these MUST be filled out or your physical will be returned*.</i></b>
Contact name / relationship to you/ day time phone number:
Contact name/ relationship to you/ day time phone number:

<b>Insurance Information:</b>
<b><i>All student-athletes participating in Cornell College athletics are required to show proof of a primary insurance policy during your competition season. This policy may be part of your parents/guardians primary insurance policy or may be in the athlete's own name. Please also make sure that your primary insurance covers you in the Mount Vernon, Iowa area. If it does not you may be required to purchase additional primary insurance.</i></b>
<b><u>Student-Athletes <i>MUST INCLUDE</i> a copy of their insurance card (<i>FRONT &amp; BACK</i>) with this completed form.</u></b>

<b>Concussion History:</b>	
Have you ever had a head injury/concussion(s)?	YES NO
If "yes" to concussions, how many have been diagnosed by a physician?	_____
-	
Have you ever been knocked out or unconscious?	YES NO
If "yes" to being knocked out of unconscious, how many times?	_____
-	
I hereby state that, to the best of my knowledge, my answers to all of the questions on this form are correct.	
Athlete's Signature _____	Date: _____
Parent/Guardian Signature: _____	Date: _____

# Cornell College Athletics

## Preparticipation Physical Evaluation

**HISTORY FORM**

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Birthdate \_\_\_\_\_ Sport \_\_\_\_\_  
Last First MI

Year in School \_\_\_\_\_ SSN \_\_\_\_\_ Cell # \_\_\_\_\_

School Address \_\_\_\_\_

Parent's Name \_\_\_\_\_

**Explain "Yes" answers below**  
**Circle questions you don't know the answers to.**

- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |  | <b>Yes</b>               | <b>No</b>                |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition? (like diabetes or asthma)  | <input type="checkbox"/> | <input type="checkbox"/> | 26. Were you born without or are you missing a kidney, eye, a testicle, or any other organ?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non-prescription (OTC) medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/> | 28. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you had a herpes skin infection or cold sore?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (Check all that apply):<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, Echocardiogram)   | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died under the age of 50 for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/> | 36. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before the age of 50?   | <input type="checkbox"/> | <input type="checkbox"/> | 37. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> | 38. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/> | 39. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle area below:  | <input type="checkbox"/> | <input type="checkbox"/> | 41. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:   | <input type="checkbox"/> | <input type="checkbox"/> | 43. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 44. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 45. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

46. Have you ever had a menstrual period?
47. How old were you when you had your first menstrual period? \_\_\_\_\_
48. How many periods have you had in the last 12 months? \_\_\_\_\_

**Explain "Yes" answers here:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?
21. Do you regularly use a brace or assistive device?
22. Has a doctor ever told you that you have asthma or allergies?
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?
24. Is there anyone in your family who has asthma?

Adapted from the 2004 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize the Ebersole Student Health Center to release any information related to my athletic participation to the Cornell College's Sports Medicine Department. And for Cornell College's Sports Medicine Department to release any medical information to Ebersole Student Health Center or to Cornell College's Insurance Company claims administration services.

Athlete Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return to: Sports Medicine Department  
Cornell College  
Multi-Sport Center  
600 1st Street SW  
Mount Vernon, IA 52314

Questions can be directed to: Eric Dybvig, MA, LAT, ATC  
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edybvig@cornellcollege.edu