

Cornell College Athletics
Preparticipation Physical Evaluation

ATHLETE INFORMATION FORM

2009-2010

Cornell College Pre-Participation Physical Evaluation for **RETURNING** Student-Athletes.

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

All returning athletes must have the athlete information, history, physical exam, and clearance from completed and turned in by **Friday/ July 31, 2009** for **fall** sports and refer to checklist for other sports 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: _____

College Address (mailbox #) and Phone Number:

Home Mailing Address and Phone Number:

Emergency Contacts: *Two of these MUST be filled out or your physical will be returned*.

Contact name / relationship to you/ day time phone number:

Contact name/ relationship to you/ day time phone number:

Insurance Information:

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.

Student-Athletes MUST INCLUDE a copy of their insurance card (FRONT & BACK) with this completed physical

Concussion History:

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: _____

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HISTORY FORM

Date of exam _____

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.

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 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): | | | 33. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur | | | 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"/> |
| <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | | | 35. Have you ever been unable to move your arms or legs after being hit or falling? | <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"/> | 36. When exercising in the heat, do you have severe muscle cramps or become ill? | <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"/> | 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"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Have you had any problems with your eyes or vision? | <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"/> | 39. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you trying to gain or lose weight? | <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"/> | 43. Has anyone recommended you change your weight or eating habits? | <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"/> | 44. Do you limit or carefully control what you eat? | <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"/> | 45. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

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? Yes No
21. Do you regularly use a brace or assistive device? Yes No
22. Has a doctor ever told you that you have asthma or allergies? Yes No
23. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
24. Is there anyone in your family who has asthma? Yes No

FEMALES ONLY

46. Have you ever had a menstrual period? Yes No

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: _____

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 _____

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CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of Birth _____

Cleared without restrictions

Cleared, with recommendation for further evaluation or treatment for: _____

Not cleared for: All Sports Certain Sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

IMMUNIZATIONS (eg, tetanus/diphtheria/pertussis; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation) Not up to date Specify _____

Name of Physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician _____, MD or DO

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, MS, LAT, ATC
319-895-4009