INTRODUCTION & INSTRUCTIONS

Welcome to The University of Findlay!

All student athletes are required to turn in The University of Findlay Pre-participation Physical Examination and The University of Findlay Athletic Insurance Information **prior** to any type of participation in any intercollegiate sports at The University of Findlay.

You may send these papers in to the Athletic Training Department prior to your arrival on campus, or may bring them with you to present them directly to your team's certified athletic trainer.

The address for sending these papers is: The University of Findlay Athletic Training Department 1000 N. Main Street Findlay, OH 45840

If you have any questions, please feel free to contact The University of Findlay's Athletic Training Department at (419) 434-6785 or by email at: mailto:hanks@findlay.edu?subject=Physical Form/General Form Question.

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The University of Findlay Athletic Training Department

PRE-PARTICIPATION PHYSICAL EXAM

This is a screening evaluation and is not meant to, nor should it take place of a standard complete physical examination.

Date _	Name	Sport										
SS#_	Date of Birth	Sex			Year in Sport			1	2	3	4	5
School A	Address			P	hone	_()					
Parent/C	Guardian			P	hone	()					
Address												
Address	Street		City			S	tate			Zip		
	DI EACE ANGWED THE FOLLOWIN	ic ou	ECTI		H DE	DATE A	G BOGG	ant e				
	PLEASE ANSWER THE FOLLOWIN Please check the appropri	-						SIBLE	•			
Have yo	ou had a severe viral infection in the last	Y	N	Comments								
•	month? (ex. mono, myocarditis, etc.)	()	()									
Have yo	ou ever:											
	Been hospitalized or had any surgery?	()	()									
	Broken a bone, or had a muscle injury?	()	()									
Has any	yone in your immediate family ever had:											
	Diabetes (high blood sugar)?	()	()									
	Sudden death (age less than 50)?	()	()									
	High blood pressure?	()	()									
	Heart attack (age less than 50)?		()									
	Asthma?	()	()									
	High cholesterol?	()	()									
Have yo	ou ever had or do you now have:											
	Chest pain with or after exercise?	()	()									
	Dizziness with or after exercise?	()	()									
	High blood pressure		()									
	Racing of the heart/irregular rhythm?	()	()									
	Heart murmur?	()	()									
	Passed out with exercise?	()	()									
Have yo	ou ever had or do you now have:											
	Wheezing/cough with exercise, asthma?	()	()									
	Weakness, fatigue, or anemia?	()	()									
Have yo	ou had or do you now have:											
	Hearing loss or perforated eardrum?	()	()									
	Headaches or migraines?	()	()									
	Dental plate or orthodontic work?	()	()									
	Impaired vision, wear glasses/contacts?	()	()	Glasses / Contac	cts / Bo	oth (ple	ase circle	e)				
	Unequal pupils? If Yes, R or L larger?	()	()									
Have yo	ou ever had:											
	Heat exhaustion or intolerance?	()	()	·								
	Frequent anxiety, depression, insomnia?	()	()									
Have yo	ou had or do you now have:											
	Hernia?	()	()									
	Loss of function or absence of testicle (males)?	()	()									
	Weight problem (or recent weight gain/loss)?	()	()									
Have yo	ou in the past, or do you currently use:											
	Cigarettes or chewing tobacco?	()	()									
	Supplements (including creatine)?	()	()									
	Steroids?	()	()	-								
	Vitamins?	()	()	-								
	Weight loss meds, laxatives, self-induced vomiting?	()	()									

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If yes, indicate type of injury, ankle and dates. R L Did you have surgery? If Yes, when? Did you undergo rehabilitation? Have you ever worn a special brace, or had modifications made in equipment worn? If Yes, indicate reason, duration worn. Have you ever had a stress fracture? If Yes, when indicate leastion, and treatment to the stress of the st	List any allergies:								
Loss of consciousness? Concussion? Convulsions (seizures) or epilepsy? Singer, "burner" or "pinched nerve"? Have you ever had a neck injury of any kind? If yes, temporary or longstanding, type of injury. Explain Have you ever had any back injury/pain? If yes, indicate type of injury, shoulder, and dates. R L Did you have surgery? If Yes, when? Did you undergo rehabilitation? If yes, indicate type of injury, shee and dates. R L Did you dergo rehabilitation? If yes, indicate type of injury, shee and dates. R L Did you have surgery? If yes, when? Did you undergo rehabilitation? If yes, indicate type of injury, shee and dates. R L Did you have surgery? If yes, when? Did you undergo rehabilitation? If yes, indicate type of injury, shee and dates. R L Did you have surgery? If yes, when? Did you undergo rehabilitation? If yes, indicate type of injury, shee and dates. R L Did you have surgery? If yes, when? Did you undergo rehabilitation? If yes, indicate type of injury shee and dates. R L Did you have surgery? If yes, when? Did you undergo rehabilitation? If yes, when? Did you undergo rehabilitation? If yes, sheen indicate location, and treatment. Have you ever worn a special brace, or had modifications made in equipment worn? If yes, sheen, indicate location, and treatment. Have you ever had a stress fracture? If yes, sheen, indicate location, and treatment. Have you ever had a stress fracture? Last menstrual period?	Date of last tetanus shot:								
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Longest time between periods in last year. Age at first period? Last menstrual period?		()	()						
Last menstrual period?		_							
		_							
I attest that the above information is correct and complete to my knowledge.	Last menstrual period?	_							
I attest that the above information is correct and complete to my knowledge.									
Signature Date									

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PHYSICAL EXAMINATION (To be completed by physician)

Date		Nar	me	Sport								
Blood Pressure			Pulse	Height			Weight					
Vision: R 20/			L 20/	Corrected		Yes / No						
	N	ml	Abnml	Comments								
HEENT	()	()									
Cardiac	()	()									
Lungs	()	()									
Skin	()	()									
Abdominal	()	()									
Genitalia	()	()									
Upper Extremity Joints	()	()									
Lower Extremity Joints	()	()									
Spine & Musculature	()	()									
Other:												
Other.												
Clearance for ath Clearance pendin Referral to other	letic g fui healt	partice rther earch	cipation wi evaluation e professio	Comments								
Clearance with li Disqualified from					_							
Disquanned from	i con	преш	ion. (Fleas	_	Continue expla	nation on additional sheet if needed.						
Name of Examining Physics	siciai	n										
Address												
						Phy	rsician's Stamp					
Phone ()												
Signature					Date							

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