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.

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 Address _____ Phone ( ) _____

Parent/Guardian _____ Phone ( ) _____

Address _____
Street City State Zip

PLEASE ANSWER THE FOLLOWING QUESTIONS IN AS MUCH DETAIL AS POSSIBLE.
Please check the appropriate box. Please comment on all yes answers.

	Y	N	Comments
Have you had a severe viral infection in the last month? (ex. mono, myocarditis, etc.)	( )	( )	
Have you ever:			
Been hospitalized or had any surgery?	( )	( )	
Broken a bone, or had a muscle injury?	( )	( )	
Has anyone 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 you 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 you ever had or do you now have:			
Wheezing/cough with exercise, asthma?	( )	( )	
Weakness, fatigue, or anemia?	( )	( )	
Have you 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 / Contacts / Both (please circle)
Unequal pupils? **If Yes, R or L larger?**	( )	( )	
Have you ever had:			
Heat exhaustion or intolerance?	( )	( )	
Frequent anxiety, depression, insomnia?	( )	( )	
Have you had or do you now have:			
Hernia?	( )	( )	
Loss of function or absence of testicle (males)?	( )	( )	
Weight problem (or recent weight gain/loss)?	( )	( )	
Have you in the past, or do you currently use:			
Cigarettes or chewing tobacco?	( )	( )	
Supplements (including creatine)?	( )	( )	
Steroids?	( )	( )	
Vitamins?	( )	( )	
Weight loss meds, laxatives, self-induced vomiting?	( )	( )	

List any current medications (include over the counter and birth control pills, vitamins, supplements and inhalers)

List any allergies: _____

Date of last tetanus shot: _____

Have you ever had:	**Y**	**N**	**Comments**
Loss of consciousness?	( )	( )	
Concussion?	( )	( )	
Convulsions (seizures) or epilepsy?	( )	( )	
"Stinger", "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, temporary or longstanding, location, dates.			
Any special x-rays?	( )	( )	
Did you undergo rehabilitation?	( )	( )	
Have you ever sustained a shoulder injury?	( )	( )	
If yes, indicate type of injury, shoulder, and dates.			
R **L**			
Did you have surgery?	( )	( )	
If **Yes**, when? _____			
Did you undergo rehabilitation?	( )	( )	
Have you ever sustained a knee injury?	( )	( )	
If yes, indicate type of injury, knee and dates.			
R **L**			
Did you have surgery?	( )	( )	
If **Yes**, when? _____			
Did you undergo rehabilitation?	( )	( )	
Have you ever sprained your ankle?	( )	( )	
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 location, and treatment.			
Have you ever been treated for a mental condition?	( )	( )	
If **Yes**, specify when, where, and nature of condition.			
Do you have any other medical or physical condition not mentioned?	( )	( )	
Explain.			

Females

Have you had or do you now have menstrual irregularities or absence of menses?	( )	( )	
Longest time between periods in last year. _____			
Age at first period? _____			
Last menstrual period? _____			

I attest that the above information is correct and complete to my knowledge.

Signature _____ Date _____

PHYSICAL EXAMINATION
(To be completed by physician)

Date _____ Name _____ Sport _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision: R 20/ _____ L 20/ _____ Corrected Yes / No

	Nml	Abnml	Comments
HEENT	( )	( )	_____
Cardiac	( )	( )	_____
Lungs	( )	( )	_____
Skin	( )	( )	_____
Abdominal	( )	( )	_____
Genitalia	( )	( )	_____
Upper Extremity Joints	( )	( )	_____
Lower Extremity Joints	( )	( )	_____
Spine & Musculature	( )	( )	_____
			_____

Other: _____

I certify that I have reviewed the history and examined the above student and I recommend:

		Comments
_____	Clearance for athletic participation with no limitations.	_____
_____	Clearance pending further evaluation or testing. (Please explain)	_____
_____	Referral to other health care professional prior to clearance. (Please explain)	_____
_____	Clearance with limitations. (Please explain)	_____
_____	Disqualified from competition. (Please explain)	_____

Continue explanation on additional sheet if needed.

Name of Examining Physician _____

Address _____

_____

Physician's Stamp

Phone ( ) _____

Signature _____ Date _____