MONTREAT COLLEGE ATHLETIC DEPARTMENT
SPORT PRE-PARTICIPATION EXAMINATION FORM

Student's Name: _____ Age: _____ Sex: _____

This is a screening examination for participation in Montreat College sports. This does not substitute for a comprehensive examination with your regular physician where preventative health information can be covered. Please answer all the questions to the best of your knowledge. If you do not understand or don't know the answer to a question please ask your doctor. Not disclosing accurate information may put you at risk during a sports activity.

Please Explain "Yes" answers in the space provided below	Yes	No
Do you have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.? List: _____	☐	☐
Are you presently taking any medications or pills?	☐	☐
Do you have any allergies (medicine, bees or other stinging insects, latex)?	☐	☐
Do you have sickle cell trait?	☐	☐
Have you ever had a head injury, been knocked out, or had a concussion?	☐	☐
Have you ever had a heat injury (heat stroke) or severe muscle cramps with activities?	☐	☐
Have you ever fainted or passed out or nearly passed out during exercise, emotion, or stress?	☐	☐
Have you ever fainted or passed out AFTER exercise?	☐	☐
Have you had extreme fatigue (been really tired) with exercise (different from other athletes)?	☐	☐
Have you ever had trouble breathing during exercise, or a cough with exercise?	☐	☐
Have you ever been diagnosed with exercise-induced asthma?	☐	☐
Has a doctor ever told you that you have high blood pressure?	☐	☐
Has a doctor ever told you that you have a heart infection?	☐	☐
Has a doctor ever ordered an EKG or other test for your heart, or have you ever been told you have a heart murmur?	☐	☐
Have you ever had discomfort, pain, or pressure in your chest during or after exercise or felt your heart racing or skipping beats?	☐	☐
Have you ever had a seizure or been diagnosed with unexplained seizure problem?	☐	☐
Have you ever had a pinched nerve, stinger, or burner?	☐	☐
Have you ever had problems with your vision or eyes?	☐	☐
Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? Please List _____	☐	☐
Have you ever had an eating disorder, or do you have concerns about your eating habits or weight?		
Have you ever been hospitalized or had surgery? Please List _____	☐	☐
Have you had a medical problem or injury since your last evaluation?	☐	☐

FAMILY HISTORY

Has any family member had a sudden, unexpected death before age 50?	☐	☐
Has any family member had unexplained heart attacks, fainting or seizures?	☐	☐
Do any of your immediate family members have sickle cell disease?	☐	☐

Please explain any questions you answered "Yes":

_____

By signing below, I agree that I have reviewed and answered each question thoroughly and accurately to the best of my knowledge. I give consent for the following sports physical. If you are under 18 years of age please have your parent or guardian sign this form giving permission for the physical and allowing you to play sports at Montreat College.

Signature of Athlete: _____ Date: _____ Phone #: _____

Signature of Parent/Legal Guardian (if student is less than 18 Years): _____ Date: _____

PHYSICAL EXAMINATION

Must be completed by a Physician, Nurse Practitioner, or Physician Assistant

Athlete's Name _____ Age _____ Date of Birth _____

Permanent Address: _____

Phone Number: _____ Email Address: _____

Contact in Case of Emergency (name/ phone number): _____

Blood Pressure_____ Pulse_____ Height _____ Weight _____ BMI_____

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

System Examined	Normal	Abnormal	Comments
HEENT			
Respiratory/Lungs			
Cardiovascular/Pulses			
Abdomen/Hernia			
Skin			
Neck/Back			
Upper Extremity Joints			Inclusive of: shoulder, elbow, wrist, hand
Lower Extremity Joints			Inclusive of: hip, knee, ankle, feet
Metabolic/Endocrine			
Mammary			
Genitalia			
Reflexes			
Other			

Clearance:

☐ Cleared for complete athletic involvement

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for: ☐ Collision ☐ Contact ☐ Non-contact

Due to: _____

_____

_____

Additional Recommendation/Rehab Instructions: _____

_____

_____

_____

Date of exam: _____ Printed Name of Physician/Extender: _____

Signature of Physician/Extender: _____ MD DO PA NP

(Signature and circle of designate degree required)

Address: _____

Provider Office Stamp

_____

Phone: _____