

Athlete's Name: _____	Sport: _____
Student ID (Or SSN): _____	Birth Date: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Home Phone: _____	Cell Phone: _____ Email Address: _____

**TO THE STUDENT-ATHLETE GETTING THIS EXAMINATION**

- 1) **Make an appointment for a physical exam** with a community provider (physician or medical clinic).
- 2) **Complete the Health History part of this form** prior to your physical exam appointment.
- 3) **Gather your official immunization records** to bring to your physical exam appointment.
- 4) **Attend your physical exam appointment.**
- 5) **Bring the completed forms in person to SRJC's Student Health Services department**, along with your immunization records, and minor consent form, if applicable (Make sure to identify yourself clearly to the front office staff, there are several forms for you to sign).

**TO THE CLINICIAN COMPLETING THIS EXAMINATION**

- 1) **Review the attached Health History** (that the student has already completed), and indicate disposition of pertinent positives.
- 2) **Complete the physical examination.**
- 3) **Summarize findings** of the history and exam.
- 4) **Review the student-athlete's immunization records** to see if they are current, and update as needed. For participation in SRJC's Athletics program, students must have completed two MMRs since birth and have had a Tetanus shot within the last 10 years.
- 5) **Indicate medical clearance status**, i.e. whether this student-athlete is clinically cleared to fully participate in the sport selected, or if there are restrictions or follow-up needed to assure his/her participation will be safe.

**Health History**

**TO BE COMPLETED BY THE STUDENT-ATHLETE BEFORE THE PHYSICAL EXAM**

<i>Circle the number of any question to which you don't know the answer</i>	Yes	No	If YES, explain with DATES
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have an ongoing medical condition (like diabetes or asthma)?			
3. Are you currently taking any prescription or nonprescription medicines or pills?			
4. Do you have allergies to medicines, pollens, foods or stinging insects?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?			
7. Does your heart race or skip beats during exercise?			
8. Has a doctor ever told you that you have (check) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection			
9. Has a doctor ever ordered a test for your heart? (example: EKG, echocardiogram)			
10. Has anyone in your family died for no apparent reason?			
11. Does anyone in your family have a heart problem?			
12. Has any family member / relative died of heart problems or of sudden death before age 50?			
13. Does anyone in your family have Marfan syndrome?			
14. Have you ever spent the night in a hospital?			
18. Have you ever had surgery?			

*(This form must be complete to be valid)*

**If you answer YES to any of the following questions (16-18) indicate the type of injury, next to the body part that was injured. Include the DATE of the injury and, if relevant, treatment done.**

16. Have you ever had an injury, like a sprain, muscle or ligament tear, that caused you to miss a practice or game?

17. Have you had any broken or fractured bones or dislocated joints?

18. Have you had an injury that required x-rays MRI, CT, surgery, injections, rehab, physical therapy, a brace, a cast, or crutches?

Head: \_\_\_\_\_

Neck: \_\_\_\_\_

Shoulder: \_\_\_\_\_

Upper Arm: \_\_\_\_\_

Elbow: \_\_\_\_\_

Forearm: \_\_\_\_\_

Hand/Fingers: \_\_\_\_\_

Chest: \_\_\_\_\_

Upper Back: \_\_\_\_\_

Lower Back: \_\_\_\_\_

Hip: \_\_\_\_\_

Thigh: \_\_\_\_\_

Knee: \_\_\_\_\_

Calf/Shin: \_\_\_\_\_

Ankle: \_\_\_\_\_

Foot/Toes: \_\_\_\_\_

<i>Circle the number of any question to which you don't know the answer</i>	Yes	No	If YES, explain with DATES
19. Have you ever had a stress fracture?			
20. Do you regularly use a brace or assistive device?			
21. Has a doctor ever told you that you have asthma or allergies?			
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
23. Have you ever used an inhaler or taken asthma medicine?			
24. Were you born without or are you missing a kidney, an eye, a testicle or another organ?			
25. Have you had mono within the last month?			
26. Do you have any rashes, pressure sores, or other skin problems			
27. Have you ever had a head injury or concussion?			
28. Have you been hit in the head and been confused or lost your memory?			
29. Have you ever had a seizure?			
30. Do you have headaches with exercise?			
31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
32. When exercising in the heat, do you have severe muscle cramps or become ill?			
33. Has a doctor told you that you or a family member has sickle cell trait or sickle cell disease?			
34. Have you had any problems with your eyes or vision?			
35. Do you wear glasses, contact lenses, or protective eyewear, such as goggles or a face shield?			
36. Are you happy with your weight?			
37. Are you trying to gain or lose weight?			
38. Has anyone recommended you change your weight or eating habits?			
39. Do you limit or carefully control what you eat?			

**I certify that the information given is correct to the best of my knowledge.**

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

*(This form must be complete to be valid)*

**Athlete's Name:** \_\_\_\_\_ **Sport:** \_\_\_\_\_

### Immunization Review

To be eligible to compete on an athletic team at the SRJC an athlete must have records of two MMR vaccines since birth and a tetanus shot within the past ten years.  
If you can confirm the dates that this student has receive these vaccines you may enter those dates here.

MMR #1: \_\_\_\_\_ MMR #2: \_\_\_\_\_ Td/Tdap: \_\_\_\_\_

 The athlete elected not to receive any vaccinations today, did not bring any immunization records to the appointment, and I to not have any immunization records for the athlete at this office.

### Screenings/ Vitals

<b>Height and Weight:</b>	<b>Blood Pressure &amp; Pulse:</b>	<b>Urine Testing:</b>	<b>Vision:</b>
Height: _____	<small>(To Clear: BP: 140/90 or less, Pulse: &lt;100)</small>	<small>(To Clear: Protein: neg. or trace Glucose: neg.)</small>	<small>(To Clear: 20/40 or better in both eyes)</small>
Weight: _____	BP: _____	Protein: _____	<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected
	Pulse: _____	Glucose: _____	Left Eye: _____
			Right Eye: _____
			Both Eyes: _____

### Physical Exam

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Eyes/ears/nose/throat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Hearing	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Lymph Nodes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Heart	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Murmurs	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Rhythm	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Lungs	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Teeth	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Hernia	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Genitourinary <small>(males only)</small>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____

### Musculoskeletal Exam

Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Back	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Shoulder/Arm	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Elbow/Forearm	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Wrist/Hand/Fingers	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Hip/Thigh	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Knee	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Ankle	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____
Foot/Toes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal: _____

## Health History and Exam Summary

Clarifications and recommendations if any:

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## Medical Clearance Status

- Full medical clearance to participate in SRJC's athletics program without restriction.
- Medical clearance to participate in SRJC's athletics program with the following restrictions:  
\_\_\_\_\_  
\_\_\_\_\_
- Medical clearance to participate in SRJC's athletics program is pending until student provides us with the following records, or this follow-up action is taken:  
\_\_\_\_\_  
\_\_\_\_\_
- No medical clearance to participate in SRJC's athletics program (see Exam Summary above).

\_\_\_\_\_  
Signature of clinician completing exam

\_\_\_\_\_  
Degree

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of clinician (Please print)

**Clinic/Office stamp with address and phone number or business card required**

### **For SRJC Student Health Services use only**

\_\_\_\_\_ NSOS

\_\_\_\_\_ Traditional

\_\_\_\_\_ Information forwarded to NP/MD/TR

\_\_\_\_\_ Immunization records confirmed & entered

\_\_\_\_\_ Coach and Equipment room notified

*(This form must be complete to be valid)*