



**Pre-Participation Health History**

Name (Print)		Today's Date:
Year (circle one) FY SO JR SR 5 <sup>th</sup>	Sex (circle one): M F	Birth Date:
Sport(s):	Social Security #	

**Parent/Guardian Information**

Father:	Mother:
Address:	Address:
City/State/Zip:	City/State/Zip:
Telephone:	Telephone:

**Medical History** (to be completed by student)

Please answer the following questions in as much detail as possible. Please check the appropriate box and comment on all yes answers.

	Yes	No	Comments/Dates
<b>1. Have you had or do you have any allergies?</b> If Yes, please list			
<b>2. Have you had a severe viral infection in the past month?</b> (ex: Mono, Myocarditis, etc.)			
<b>3. Have you ever:</b> Been hospitalized or had any surgery? Missed time due to a broken bone or muscle injury?			If yes, dates and circumstances:
<b>4. Has anyone in your immediate family ever had:</b> Sudden death (before the age of 50)? High blood pressure? Heart Attack (before the age of 50)? High cholesterol?			
<b>5. Have you ever or do you now have:</b> Chest pain with or after exercise? Dizziness with or after exercise? High blood pressure? Irregular heart beat? Heart murmur? Passed out during exercise? Kidney/Bladder problems? Liver problems (hepatitis, jaundice)? Thyroid disorder? Diabetes Type I or II? Hypoglycemia? A blood disorder? Abdominal problems (IBS, Crohn's, Ulcers) A skin disorder (psoriasis, eczema)			
<b>6. Have you ever or do you now have:</b> Wheezing/cough with exercise? Weakness, fatigue or anemia? Asthma?			If yes, do you use medication/inhaler?
<b>7. Have you ever had:</b> Weight problem (or unexplained weight gain/loss)? Used weight loss meds, laxatives, self-induced vomiting			

<b>8. Have you ever or do you now have:</b> Hernia? <b>Males:</b> Loss of function or absence of testicle(s)?	<input type="checkbox"/> <input type="checkbox"/>	If yes, explain.
<b>9. Have you ever suffered from:</b> Heat exhaustion or heat related illness?	<input type="checkbox"/> <input type="checkbox"/>	
<b>10. Have you ever or do you now have:</b> Hearing problems or a perforated eardrum? Impaired vision, wear glasses or contacts? Unequal pupil size? If <b>Yes</b> which is larger??	<input type="checkbox"/> <input type="checkbox"/>	If yes, explain.
<b>11. Have you in the past, or do you currently use:</b> Cigarettes or chewing tobacco? Alcohol? Any dietary supplements? Vitamins?	<input type="checkbox"/> <input type="checkbox"/>	If yes, what and quantity.
<b>12. Have you ever had:</b> Headaches or migraines? Loss of consciousness? Concussion? Convulsions (seizures) or epilepsy?	<input type="checkbox"/> <input type="checkbox"/>	
<b>13. Have you ever had a neck injury of any kind?</b> “Stinger”, “burner” or “pinched nerve”? If <b>Yes</b> , list type of injury, temporary or long standing?	<input type="checkbox"/> <input type="checkbox"/>	
<b>14. Have you ever had a back injury or pain of any kind?</b> Any special x-rays or tests? Did you undergo rehabilitation? If <b>Yes</b> , list type of injury, temporary or long standing? Explain.	<input type="checkbox"/> <input type="checkbox"/>	
<b>15. Have you ever sustained a shoulder injury?</b> Did injury require surgery? Did you undergo rehabilitation? If <b>Yes</b> , please indicate type of injury, side and dates.	<input type="checkbox"/> <input type="checkbox"/>	
<b>16. Have you ever sustained a knee injury?</b> Did injury require surgery? Did you undergo rehabilitation? If <b>Yes</b> , please indicate type of injury, side and dates.	<input type="checkbox"/> <input type="checkbox"/>	
<b>17. Have you ever sustained an ankle injury?</b> Did injury require surgery? Did you undergo rehabilitation? If <b>Yes</b> , please indicate type of injury, side and dates.	<input type="checkbox"/> <input type="checkbox"/>	
<b>18. Have you ever worn a special brace or required special modifications in your equipment?</b> If <b>Yes</b> , indicate reason, time worn.	<input type="checkbox"/> <input type="checkbox"/>	
<b>19. Have you ever had a stress fracture?</b> If <b>Yes</b> , indicate when, location and treatment	<input type="checkbox"/> <input type="checkbox"/>	
<b>20. Have you ever been treated for a mental condition?</b> <b>Have you had frequent anxiety, depression or insomnia?</b> If <b>Yes</b> , specify when, where and nature of condition.	<input type="checkbox"/> <input type="checkbox"/>	
<b>21. Do you have any other medical condition not previously addressed?</b> If <b>Yes</b> , explain	<input type="checkbox"/> <input type="checkbox"/>	
<b>22. Are you currently under a Physician’s, Chiropractor’s, or Physical Therapist’s care?</b> If <b>Yes</b> , explain.	<input type="checkbox"/> <input type="checkbox"/>	
<b>23. Females:</b> Do you have regular periods? Do you or have you had menstrual irregularities?	<input type="checkbox"/> <input type="checkbox"/>	
<b>24. List any current medications taken on a regular basis:</b> Include prescription and over-the-counter	<input type="checkbox"/> <input type="checkbox"/>	

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

**Physician’s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Athlete’s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# ADRIAN COLLEGE

110 S. Madison ■ Adrian, MI 49221 ■ PHONE: 517.264.3969 ■ FAX: 517.264.3802

## Physical Exam

(to be completed by physician)

Name: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Sport(s): \_\_\_\_\_

### Vitals

Weight:	Height:	Pulse:
Vision: R: 20/_____ L: 20/_____	Blood Pressure: ____ / ____	
Corrected (circle all that apply) YES NO Glasses Contacts		
Allergies:	Td (per medical record):	

Problems identified in Health History: \_\_\_\_\_

### Physical Examination (To be completed by physician)

Examination	Normal	Abnormal	Comments
1. Head			
2. Eyes			
3. Ears			
4. Nose			
6. Throat/Neck			
7. Heart			
8. Lungs			
9. Abdomen			
10. Hernia			
11. Nervous			
12. Shoulders			
Knees (circle all normal) Rt. MCL LCL ACL PCL Lt. MCL LCL ACL PCL			

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

- \_\_\_ 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 participation (Please explain)

Name of Examining Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Adrian College Authorized Medical Staff ONLY:**

*Clear to participate*

ATC/RN Signature \_\_\_\_\_ Date \_\_\_\_\_  Yes  No (If no see attached notes)



**Athletic Release**

**Directions:** The following documentation is to be read carefully. If you are under 18 years of age, your parent or guardian must also sign. If you decline to sign any portion of this authorization document, please sign the “Decline” space.

**Authorization To Use Or Disclose Protected Health Information**

I hereby authorize the Adrian College Athletic Training Department and their representatives to release and/or obtain my protected health information for the purpose of treating injuries sustained while participating in intercollegiate athletics.

If I wish to revoke this authorization, I must do so in writing and have such authorization on file with the Adrian College Athletic Training Department.

\_\_\_\_\_  
Print Name Signature

\_\_\_\_\_  
Date Parent/Guardian Signature (if under 18)

\_\_\_\_\_  
Signature to Decline

**Medical Consent Authorization**

I hereby grant permission to the Adrian College Athletic Training Department and Team Physician/Consultants to render to myself, and/or son/daughter, any treatment or medical care deemed reasonably necessary. This includes preventative care, first aid, rehabilitation and emergency treatment. Also, if deemed necessary, I grant permission for hospitalization.

\_\_\_\_\_  
Print Name Signature

\_\_\_\_\_  
Date Parent/Guardian Signature (if under 18)

\_\_\_\_\_  
Signature to Decline

**Authorization To Notify Parents/Guardian Of Injury/Illness Sustained While Participating In Athletics**

I the undersigned, do hereby give my permission for the Adrian College Athletic Training Department and their representatives to release information concerning my condition/injury to my parent/guardians listed below. All pertinent facts concerning my condition may be communicated to the party(ies) indicated below.

\_\_\_\_\_  
Name of parent/guardian (PRINTED) Name of parent/guardian (PRINTED)

\_\_\_\_\_  
Print Name Signature

\_\_\_\_\_  
Date Parent/Guardian Signature (if under 18)

\_\_\_\_\_  
Signature to Decline



## Student-Athlete Acknowledgement of and Assumption of Risk

The undersigned hereby formally acknowledges and declares the following:

I understand that participation in sports requires a personal acceptance of risk of injury. Athletes generally expect that those who are responsible for the conduct of the sport take reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict wrongful injury upon them.

I understand that participation in Intercollegiate Athletics at Adrian College may result in injury/illness, permanent physical or mental impairment, or even death. These injuries may be minor or may be career or life threatening. I understand that Adrian College cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques which are made known to me by the coaching staff or athletic training staff, or are otherwise known to me from another source including but not limited to medical personnel of the college.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for **any and all** such risks while participating in Intercollegiate Athletics at Adrian College. I also agree to the following:

- A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics.
- B. I accept that Adrian College and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have.
- C. I understand that having passed a physical examination **does not** necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at Adrian College, but only that the evaluator did not find a medical reason to disqualify me at **the time of the physical examination.**
- D. I understand that I must refrain from practice when injured or ill, whether or not receiving care. When under medical care, I may not return to participation until I have been given permission, based on independent exercise of professional judgment, by the attending Team Physician(s) or his/her designate after review of my condition and fitness for the rigors of my sport. This may occur only at the conclusion of medical treatment(s).
- E. I understand and agree that if I experience an injury/illness or change in my health status **it is my responsibility** to inform the Certified Athletic Trainer in charge of my sport and to adhere to the established injury management guidelines which include total rehabilitation and reassessments before I am released to return to full participation.
- F. I understand that I must wear the proper equipment as dictated by the rules of the sport. I may also have to wear padding or braces as indicated by the athletic training staff or medical personnel. Failure to do so may put me at risk for further injury.

**I HAVE READ, UNDERSTAND AND HAVE VOLUNTARILY AGREED TO THE ABOVE STATEMENTS.**

\_\_\_\_\_  
Print Name Sport(s)

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent/Guardian Signature (if under 18) Date