

PRE-PARTICIPATION ATHLETIC PHYSICAL EXAMINATION

Athlete Name: _____ Age: _____ D.O.B. _____ Mail Box #: _____
 Mailing Address (Home) _____ City _____ State _____ Zip Code _____
 E-mail Address _____ Circle One: Fr. So. Jr. Sr. 5th yr
 Social Security No: _____ Sport: _____ Phone: _____ Cell: _____

Emergency Contact Information				Insurance Co. & No.	
Name			Relationship		Phone (Home)
Address	City	State	Zip	Phone (Cell)	Phone (Work)

STEP ONE Health History (to be completed by athlete):

Circle the appropriate answer (explain "Yes" below):

1. Do you have any allergies? Yes No
2. Do you take any medicines? Yes No
3. Have you ever had a heart murmur? Yes No
4. Have you ever had an irregular heartbeat? Yes No
5. Has anyone in your family died prior to age 40? Yes No
6. Have you ever been hospitalized overnight? Yes No
7. Have you ever had surgery? Yes No
8. Have you ever had a serious injury? Yes No
9. Have you ever had a head injury? Concussion/s Yes No
10. Have you ever had x-rays? Yes No
11. Have you ever had a broken bone? Yes No
12. Have you ever had a sprain/strain/dislocation? Yes No
13. Have you ever had a "stinger/burner"? Yes No
14. Have you ever passed out? Yes No
15. Have you ever had chest pain? Yes No
16. Have you ever had high blood pressure? Yes No
17. Have you ever had a seizure? Yes No
18. Have you ever had heat cramps/exhaustion/stroke? Yes No
19. Do you have any chronic diseases? Yes No
 (diabetes, hepatitis, Marfan's syndrome, mononucleosis, sickle cell anemia, kidney problems, frequent headaches, etc.)
20. Do you have asthma? Yes No
21. Have you ever had any skin conditions? Yes No
22. Do you wear glasses, contacts, braces, appliances? Yes No
23. Do you need special pads/braces for sports? Yes No
24. Females – Do you have regular menstrual periods? Yes No
25. Has it been more than 5 years since your last tetanus shot? Yes No
26. Do you have any concerns to discuss with the provider? Yes No
27. Do you use any nutritional supplements? Yes No

Explain any "Yes" answers from above

Continue on back of page if space is needed.

I authorize the release to the Athletic Department of this and any information that may affect my participation in the SVC athletic program. I furthermore know of and accept the risks involved in participation in athletics and understand that serious injury, even death, is possible in such participation and voluntarily choose to accept such risks. Any injuries sustained during athletic participation need to be reported to ATC.

ATHLETE SIGNATURE: _____
Date signed: _____

STEP TWO Medical provider to complete assessment:

Ht: _____ Wt: _____ Body Mass Index: _____
 Blood pressure: _____ Pulse (resting): _____
 Vision: _____ Left _____ Right

CHECK IF NORMAL EXPLANATION IF ABNORMAL

Eyes (incl. funduscopic)		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Chest and Lungs		
Abdomen		
Skin		
Genitalia – Hernia (Male)		

FORM COMPLETE: ____ **NOT COMPLETE :** ____
 (explain) _____

RECOMMENDED FOR FULL PARTICIPATION:

Yes _____ No _____
 Partial _____

Provider Name _____
Address _____
Phone _____

PROVIDER SIGNATURE _____
Date Signed: _____
MD/DO/CRNP

STEP THREE Athletic Trainer to complete assessment below:

CHECK IF NORMAL EXPLANATION IF ABNORMAL

Musculoskeletal (ROM, strength)		
Neck		
Spine		
Shoulders		
Arms/hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
Neuromuscular (DTR)		

Completed by (Trainer/Provider) _____

CHECK LIST

Legibly completed all information on top of form

Explained “Yes” answers in detail

Physician’s office completed physical examination for Step Two, signed and completed provider information

Step Three is left blank for St. Vincent College’s Athletic Training Staff to complete

Enclose copy of front and back of current health insurance card

If you have had a recent surgery, illness, or injury and been under the care of a medical specialist, please include a written release to participate in athletics from that specialist

Attend sport specific screening date

After you have completed the Pre-Participation Athletic Physical Examination with you physician, mail the signed form along with the copy of the front and back of your current health insurance card to:

Becky Pizer
St. Vincent College Athletics
300 Fraser Purchase Rd
Latrobe, PA 15650

All forms must be received by July 16th for all fall sports with preseason camps and by July 31st for all other sports

2008-2009 Athletic Screening Dates and Times

Sport	Date	Time
Football	Thursday Aug. 14	11 am - Noon
Men’s Soccer	Sunday Aug. 17	12:30 – 1:00 pm
Women’s Soccer	Sunday Aug 17	1:00-1:30 pm
Men’s Cross Country	Sunday Aug 17	1:30-2:00 pm
Field Hockey	Sunday Aug 17	2:00-2:30 pm
Women’s Tennis	Sunday Aug 17	2:30-3:00 pm
Volleyball	Sunday Aug 17	3:00-3:30 pm
Women’s Cross Country (Local Runners)	Sunday Aug 17	1:30 – 2:00 pm
Women’s Cross Country	Thursday Aug 21	1:00-2:00 pm
Women’s Basketball	Sunday Aug 24	6:00-6:30pm
Men’s Basketball	Sunday Aug 24	6:00-6:30pm
Men’s Swimming	Sunday Aug 24	6:30-7:00pm
Women’s Swimming	Sunday Aug 24	6:30-7:00pm
Baseball	Sunday Aug 24	7:00-7:30pm
Softball	Sunday Aug 24	7:00-7:30pm
Men’s Lacrosse	Sunday Aug 24	7:30-8:00pm
Women’s Lacrosse	Sunday Aug 24	7:30-8:00pm
Men’s Golf	Sunday Aug 24	8:00-8:30pm
Women’s Golf	Sunday Aug 24	8:00-8:30pm
Men’s Tennis	Sunday Aug 24	8:30-9:00pm
Men’s Track	Sunday Aug 24	8:30-9:00pm