

NORTHWOOD UNIVERSITY PRE-PARTICIPATION PHYSICAL FORM

HISTORY

Date: _____

Sport: _____

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip: _____ Sex: _____ Date of Birth: _____

Physician Printed Name: _____ Physician Phone: _____

Explain "yes" answers in the blanks below:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you presently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies – including medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced dizziness during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heart beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died of heart problems or a sudden death before the age of 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a seizure or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had heat cramps, heat illness, or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you use any special equipment (pads, braces, eye guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you missing an eye kidney or testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever sprained/strained, dislocated, broken, or had repeated swelling or other injuries of any bones or joints? | | |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Foot | | |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand | | |
| 25. Have you had any other medical problems or illnesses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. When was your last menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever had painful or absence of menstruation? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "yes" answers:

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date: _____ Signature of athlete: _____

Date: _____ Signature of parent/guardian: _____
(if athlete is 18 or under)

PHYSICAL EXAMINATION

DATE _____

Name: _____ Age: _____ Date of Birth: _____

Height _____ Weight _____ BP: _____ / _____ Pulse: _____
 Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils (Circle) Equal/Unequal R>L L>R

	Circle (if option given)	Specific Findings
Heart		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal <input type="checkbox"/>	Specific Findings
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal:		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not Cleared

Due to: _____

Recommendation: _____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport.

Name of Physician: _____ Date: _____

Address: _____

Phone: (_____) _____

Signature of Physician: _____