



CATAWBA COLLEGE
SPORTS MEDICINE

Preparticipation Physical
Photocopies NOT Accepted

DATE COMPLETED: SPORT: ARE YOU ADOPTED? YES NO

NAME DATE OF BIRTH SEX M / F BANNER ID

Explain "Yes" answers below. Circle questions you don't know the answer to.

- 1 Has a doctor ever denied or restricted your participation in sports for any reason?
2 Are you currently being treated by a physician for any reason?
3 Do you have any ongoing medical condition (like diabetes, asthma, or migraine headaches)?
... 27 Is there anyone in your family who has asthma?
28 Has a doctor ever told you that you have asthma or allergies?
29 Have you ever used an inhaler or taken asthma medication?
... 56 How many periods have you had in the past 12 months?

Explain "Yes" answers here:

The undersigned, herewith,

- Give authorization to the team physician, athletic trainer, physical therapist, and other sports medicine consultants to evaluate and treat any injuries that occur as a result of my athletic participation at Catawba.
Understands that I must refrain from practice or play while ill or injured, whether or not receiving medical treatment until I am discharged from treatment or am given permission by the clinical practitioner to restart participation despite continuing treatment;
Understands that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at time of said examination; and
States that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature:

Date:

Parent or Witness' Signature:

Date: P

PHOTOCOPIES WILL NOT BE ACCEPTED!



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NAME DATE OF BIRTH SPORT
HEIGHT WEIGHT BP PULSE
VISION R 20/ L 20/ CORRECTED? Y / N PUPILS EQUAL / UNEQUAL

Appearance ()
Eyes/ears/nose/throat ()
Hearing ()
Lymph Nodes ()
Cardiopulmonary
Auscultations (murmurs) Supine Standing Pulses: Brachial Femoral
Lungs ()
Marfan's ()
Arm span > height Kyphoscoliosis Concave chest + Thumb/wrist
High arch/palate/feet Inguinal Hernia Nearsighted Heart murmur
Tanner Stage 1 2 3 4 5
Skin ()
Abdomen ()
Genitourinary ()

Musculoskeletal NORMAL ABNORMAL FINDING / HISTORY
Head ()
Neck ()
Back ()
Shoulder/arm ()
Elbow/forearm ()
Wrist/hand/fingers ()
Hip/thigh ()
Knee ()
Leg/ankle ()
Foot/toes ()

Blood Sickle Cell Test Disease: Positive / Negative Trait: Positive / Negative
Urinalysis Sugar Albumin Micro, if indicated

I certify that I have on this date examined this student and that, on the basis of the examination requested by the institution and the student's medical history as furnished to me, this student is:
() CLEARED WITHOUT RESTRICTION
() CLEARED, WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:
() NOT CLEARED
() FOR ALL SPORTS
() FOR CERTAIN SPORTS Please explain / give reason

Name of Physician (print) Date

Physician Address City State Zip Phone

Signature of Physician MD or DO

Athlete's Signature Date

Parent/Guardian Signature (If athlete is under 18 years of age) Date