

CLINTON COMMUNITY COLLEGE ATHLETIC PHYSICAL

DATE: ____/____/____
Month Day Year

Student Athlete's
Name: _____
(Last) (First) (Middle Initial)

Social Security No: ____/____/____ Date of Birth: ____/____/____
Month Day Year Age Sex

Local Apartment,
Address, Dormitory, etc. _____

Local Phone: _____ Cell Phone: (____) _____

List two (2) persons to notify in case of an Emergency:

Name of First Person: _____

Relationship: _____

Address: _____
(City) (State) (Zip)

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____

Name of Second Person: _____

Relationship: _____

Address: _____
(City) (State) (Zip)

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____

Name of Family Physician: _____

Address: _____
(City) (State) (Zip)

Business Phone: (____) _____

FAMILY MEDICAL HISTORY: Has any blood relative ever had? (Please circle the correct answer)

Cancer	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Epilepsy/Seizures	Yes	No
Heart Disease	Yes	No	Chronic Lung Disease (including Asthma)	Yes	No
High Blood Pressure	Yes	No	Intestinal Disorders	Yes	No
Sickle Cell Trait/Disease	Yes	No	Kidney Disease	Yes	No
Blood Disease	Yes	No	Bleeding Disorder	Yes	No
Marfan's Syndrome	Yes	No	Raynaud's Disease	Yes	No
Died suddenly before age 50	Yes	No	Relationship(s): _____		
Other, please explain: _____					

Your Blood Type: A+ A- B+ B- AB+ AB- O+ O-
(if you know it?)

GENERAL ALLERGIES: Please answer as to whether you are allergic to the following?

Aspirin	Yes	No	Tetanus antitoxin or serums	Yes	No
Codeine	Yes	No	Novocaine or other anesthetics	Yes	No
Sulfa Drugs	Yes	No	Hay Fever (dust/mold/pollen/grass)	Yes	No
Penicillin	Yes	No	Bee/Wasp stings	Yes	No
Ibuprofen	Yes	No	Ice/Cold	Yes	No
Acetaminophen/Tylenol	Yes	No	Latex	Yes	No
Erythromycin	Yes	No	Athletic Tape	Yes	No
Iodine	Yes	No	Athletic Tape Spray	Yes	No
Bacitracin ointment	Yes	No	Band-aids/Bandages	Yes	No
Are you allergic to any other drugs, medications, foods, plants, insects, etc. not listed above? If yes , please list those allergies here:					

GYNECOLOGICAL HISTORY: *ONLY FEMALES ANSWER THIS SECTION*****

Date of last period: _____	How many days between periods? _____
How many periods during the past year? _____	Longest time between periods during the past year? _____
Are you currently taking Birth Control Pills?	Yes No
If yes, what type are you taking? _____	

GENERAL MEDICAL HISTORY: Have you ever had any of the following? **(Please circle the correct answer) If you circled yes, please explain.**

Have you ever been hospitalized or had any surgery?	Yes	No	_____
Are you under care for a chronic condition or illness?	Yes	No	_____
Are you taking any medications on a regular basis?	Yes	No	_____
Are you taking any supplements, including herbal and/or performance enhancing?	Yes	No	_____
In the 12 months, have you seen a doctor for anything?	Yes	No	_____
In the past 12 months, have you been treated for mononucleosis, pneumonia, infectious virus?	Yes	No	_____
Do you wear glasses or contacts for sports?	Yes	No	_____
Have you had a seizure?	Yes	No	_____
Have you ever been unconscious or had loss of memory from a blow to your head?	Yes	No	_____
Do you have frequent or severe headaches?	Yes	No	_____
Have you ever been told you have a type of asthma?	Yes	No	_____
Do you cough, wheeze or have trouble breathing during or after exercise?	Yes	No	_____
Do you carry an inhaler?	Yes	No	_____
If yes to inhaler question, is it a prescription?	Yes	No	Name of inhaler(s) _____
Do you have spells of dizziness, or have you ever fainted especially during or after exercise?	Yes	No	_____
Are you bothered by shortness of breath or chest pain when you are exercising or working hard?	Yes	No	_____
Do you have heart disease?	Yes	No	_____
Have you ever been you have/had a heart murmur?	Yes	No	_____
Are you bothered by a "racing" heart or a heart that "skips" heartbeats?	Yes	No	_____
Have you ever become ill from exercising in the heat?	Yes	No	_____
Are you a diabetic or ever been treated for diabetes?	Yes	No	_____
Do you or have you ever had anemia (anemic, Sickle-cell, hypoglycemia)?	Yes	No	_____
Have you ever had Rheumatic or Scarlet fever?	Yes	No	_____
Do you have high blood pressure?	Yes	No	_____
Have you ever been told you have kidney disease?	Yes	No	_____
Do you ever have long bouts of diarrhea?	Yes	No	_____
Have you recently gained or loss 10 or more pounds?	Yes	No	_____
Are you lacking an organ (i.e. spleen, kidney, eye, testicle, ovary, appendix, gall bladder, etc.)?	Yes	No	_____

GENERAL ORTHOPAEDIC/SPORTS INJURY HISTORY: Have you ever had any of the following?
(Please circle the correct answer) If you circled yes, please explain what type of injury (i.e strained, sprained, fractured, dislocated, nerve related, disc related, etc.) and when the injury occurred.

Concussion(s)	Yes	No	_____
Skull Fracture(s)	Yes	No	_____
Head/Eye/Mouth/Nose/Ear	Yes	No	_____
Throat/Neck	Yes	No	_____
Shoulder	Yes	No	_____
Elbow	Yes	No	_____
Forearm/Wrist	Yes	No	_____
Hand/Finger	Yes	No	_____
Rib/Thorax/Abdominal	Yes	No	_____
Spine	Yes	No	_____
Back	Yes	No	_____
Hip/Pelvis/Groin	Yes	No	_____
Quad/Hamstrings	Yes	No	_____
Knee	Yes	No	_____
Lower Leg/Shin Splints	Yes	No	_____
Ankle	Yes	No	_____
Foot	Yes	No	_____
Muscle pull/strain	Yes	No	_____
Hernias	Yes	No	_____

TODAY I RECEIVED THE *STUDENT ACCIDENT INSURANCE PLAN BROCHURE* AND I UNDERSTAND THAT IF I AM INJURED IT IS *MY RESPONSIBILITY* TO CONTACT THE COLLEGE NURSE WITHIN 7 DAYS.

STUDENT ATHLETE'S SIGNATURE: _____

DATE: _____

I hereby authorize the consulting physicians, nurse, athletic trainer and other health care personnel representing Clinton Community College to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, insurance carriers, academic counselors, athletic and/or college administrators. Any protected health information not directly related to my athletic participation will be kept confidential.

Student Athlete's
 Signature: _____ Date: _____

