MONTEREY PENINSULA COLLEGE

Date____________________

ATHLETIC PREPARTICIPATION HEALTH SCREENING

Name____

Date of Birth_____________________

Phone____Sex______________

Sport________________________________

Address/City/State____

Zip_______________

Emergency Contact

Name___________________________________ Relationship_____________________________

Phone______________________________________

Address/City/State____

Zip______________

Name of Family Physician______________________________________

MEDICAL HISTORY

Record of Illness: Place a check next to any condition that you have/have had within the past FIVE years.

____Concussion

If Yes, how many?

____

If Yes, when was the most recent?

____

____Allergies (If Yes, specify)____

____Appendicitis____

____Asthma____

____

____Convulsions____

____Diabetes____

____Epilepsy____

____Heart Disease____

____Hernia____

____Kidney/Bladder____

____Tonsilitis____

____Surgery (type/ date)____

Record of Symptoms: Place a check next to any condition that you have/have had.

____Difficulty hearing

____Nose Bleeds

____Headaches

____Blackouts

____Painful menstrual cramps

____Shortness of breath

____Chest pain

____High blood pressure

____Fainting spells
If you have checked any condition above, please explain in detail:
____
____
____

Eyes: Place a check next to the following that apply to you
____Wear glasses
____Contact lenses ____Hard____Soft
____Wear glasses/contact lenses when competing ____Glasses _____Contact lenses

Are you currently taking any medications at this time? (Circle) Y N If yes, please list all drugs or medications and daily usage/dosage.
____
____
Check if you have ever injured any of the following and if you had surgery for the injury:

____Face or Head
____Neck or Back
____Chest or Abdomen
____Shoulder
____Arm
____Wrist or Hand
____Leg
____Knee
____Ankle or Foot

If yes to any of the above, please give brief explanation and date of onset.
____
____
____

STOP

THE FOLLOWING WILL BE COMPLETED BY THE PHYSICIAN

HEALTH SCREENING

____________Height
____________Weight
____________Blood Pressure
____________Pulse
____________Respiratory
____________Cardiovascular
____________Left Vision,
____________Right Vision
____________Ears
____________Nose
____________Throat
____________Hernia

Shoulder:
____________ROM____
____

_____________Strength____
____
_____________Ligament
Laxity____
____
Knee:
_____________ROM____
____
_____________Strength____
____
_____________Ligament
Laxity____
____
Ankle:
_____________ROM____
____
_____________Strength____
____
_____________Ligament
Laxity____
____
Other:
_____________ROM____
____
_____________Strength____
____
_____________Ligament
Laxity____
____

COMMENTS AND RECOMMENDATIONS

I hereby certify that _____________________________________ was examined by me on ______________________. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport except _____________________ (if none, state so.)

Signature of examining physician (MUST BE MD or DO)____