

**WESLEY COLLEGE SPORTS MEDICINE
PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**

Name: _____ DOB: _____ Sport(s): _____

FOR EXAMINING PHYSICIANS ONLY

SYSTEMS Normal Abnormal

SYSTEMS	Normal	Abnormal
Head		
Ears		
Nose & Throat		
Neck		
Chest		
Heart		
Abdomen		
Genitals		
Hernia		
Other		
Musculoskeletal		
Neck		
Spine		
Shoulders		
Elbow		
Wrist		
Hand		
Knee		
Ankle		
Foot		

Height: _____ Weight: _____
 Blood Pressure: _____ / _____ Pulse: _____

VISION
 Right 20/ _____ corrected to 20/ _____
 Left 20/ _____ corrected to 20/ _____

Comments:

Physician's Statement

Release for full participation YES ___ NO ___

Not release for participation until additional exams are completed. Please explain

May not participate for the following reasons:

 Physician's Name/Signature Phone number Date

Participating Athlete:

I understand that this physical is for no other purpose than to clear me for athletic participation at Wesley College. I understand it is not a physical for illness that may develop in the future. I further agree that such illness will be taken to the athletic trainer for referral and care.

Athlete's Signature: _____ Date: _____

Student-Athlete Last Name: _____
Student-Athlete First Name: _____
Sport or Sports: _____

PART I:

Do you now have or have you had any problems in the past with:

1. Headaches (needing treatment): Yes No
2. Heart: Yes No
3. Breathing (Asthma, etc.): Yes No
4. Abdominal pain: Yes No
5. Dizzy spells: Yes No
6. Black outs: Yes No
7. Eyes (except glasses): Yes No
8. Hearing or ears: Yes No
9. Arthritis: Yes No
10. Joint pain or swelling: Yes No
11. Chronic back pain: Yes No
12. Kidneys: Yes No
13. Bladder: Yes No
14. Diabetes: Yes No
15. High blood pressure: Yes No
16. Cancer: Yes No
17. Operations or surgery: Yes No
18. Varicose veins: Yes No
19. Skin disorders: Yes No

- 20. Eating disorders: Yes No
- 21. Anemia: Yes No
- 22. Disorders of the blood: Yes No
- 23. Convulsions: Yes No
- 24. Epilepsy: Yes No
- 25. Mononucleosis: Yes No
- 26. Fainting: Yes No
- 27. Hepatitis: Yes No
- 28. Muscle cramps: Yes No
- 29. Loss of organ: Yes No

* if yes to any of the above please list number and explain

PART II:

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Have you had a previous injury or surgery on any of the following?

- 1. Head (Concussions, fractures, etc.): Yes No
- 2. Spine: Yes No

3. Abdomen: Yes No

4. Chest: Yes No

5. Shoulder: Yes No

6. Elbow: Yes No

7. Wrist: Yes No

8. Hand: Yes No

9. Hip: Yes No

10. Thigh: Yes No

11. Knee: Yes No

12. Calf or shin: Yes No

13. Ankle: Yes No

14. Foot: Yes No

* If yes to any of the above, please reference number and briefly explain:

PART III:

1. Do you have or have you been tested for Sickle Cell Trait? Yes No Not tested

2. Do you or have you ever had a heat related illness (Excessive Cramping, Heat Exhaustion, Heat Stroke)? Yes No

3. Are you allergic to any medications?

4. Please provide us with any additional information that may effect you during you participation at Wesley College (Family history or any item not mention previously):

By clicking this box, I verify that all the information listed above is correct.

Submit