

Lakeland College 2012-2013 Athletic Physical Examination Form

1. **Name:** _____
(Please print) Last First Middle

Sport(s): _____

Social Security # _____ / _____ / _____ **Sex:** M _____ F _____

Date of Birth: _____

2. **Home Address:** _____

Home Phone: (____) _____

City State Zip

Parents Work Ph: (____) _____

MEDICAL HISTORY SURVEY (To be completed by athlete prior to physical)

3. Do you have now or have you had in the past, problems with:	Yes	No
a. Breathing, e.g. asthma		
b. Heart / lungs diseases		
c. Headache / migraines		
d. Abdominal pain		
e. Dizzy spells		
f. Black outs / fainting		
g. Eyes (except glasses & contact lens)		
h. Hearing or ears		
i. Arthritis		
j. Joint pain or swelling		
k. Knees – injury or giving out		
l. Spine – back or neck		
m. Broken bones		
n. Kidneys		
o. Bladder		
p. Diabetes		
q. High blood pressure		
r. Cancer		
s. Operations or surgery		
t. Artery / vein or any blood circulatory		
u. Skin disorders		
v. Other major injuries		
w. Drug allergies		
x. Eating disorder		
y. Anemia		
z. Convulsions		
aa. Epilepsy		
bb. Mononucleosis		
cc. Fainting		
dd. Hepatitis		
ee. Brain damage		
ff. Loss of organ		

4. If you answered yes to any of #3, please give details below (identify by letter):
5. Have you ever been knocked unconscious? Yes: ____ No: ____ If yes, explain: (# of times, date of last occurrence):
6. Are you under a physician's care at the present time? Yes: ____ No: ____ If yes, explain:
7. Are you presently taking any medications, drugs, Or supplements? Give details: Yes: ____ No: ____
8a. Have you ever passed out or nearly passed out during/after exercise? Yes: ____ No: ____
b. Has anyone in your family died for no apparent reason? Yes: ____ No: ____
c. Does anyone in your family have heart problems? Yes: ____ No: ____
d. Has anyone in your family died of heart problems or sudden death before the age of 50? Yes: ____ No: ____
e. Does anyone in your family have Marfan syndrome? Yes: ____ No: ____
f. Have you ever had pain, discomfort, or pressure in your chest during exercise? Yes: ____ No: ____
g. Does your heart race or skip beats during exercise? Yes: ____ No: ____
h. Have you ever been told you have high blood pressure, high cholesterol, a heart murmur, or a heart infection? Yes: ____ No: ____
i. Has your doctor ever ordered a test for your heart? Yes: ____ No: ____
9. If you answered yes to any of #8, please give details below (Identify by letter):
10. Year of last Tetanus injection: _____
11. Females – Do you have a monthly menstrual period? Yes: ____ No: ____ Date of last period: _____ if no, explain:
12. Do you have an intense fear of gaining weight? Yes: ____ No: ____

PREVIOUS INJURY OR SURGERY

Have you had an injury lasting more than 3 days or surgery to the following? Give date(s) and explain below:

1. Head _____	2. Neck & Back _____	3. Abdomen _____	4. Chest _____	5. Shoulder _____
6. Elbow _____	7. Arm _____	8. Wrist & Hand _____	9. Hip & Thigh _____	10. Knee _____
11. Lower Leg _____	12. Ankle _____	13. Foot _____		
Explain (identify by number) _____				

Physical Form: MUST BE COMPLETED BY EXAMINING MEDICAL PROVIDERS

Athlete's Name: _____ **Date:** _____
(Please print) Last First Middle

Measurements and other Findings

- 1. Height _____
- 2. Weight _____
- 3. Blood Pressure:
Systolic _____ Diastolic _____
- 4. Pulse _____
- 5. Vision
Right: 20/____ Corrected to 20/____
Left: 20/____ Corrected to 20/____

Laboratory tests

- 6. Urinalysis (if indicated):
Glucose: _____
Protein: _____
Blood: _____
pH: _____

7. Does this athlete have the Sickle Cell Trait?
Yes _____ No _____

Clinical Evaluation

	Normal	Abnormal
7. Eyes – general		
8. Eyes		
9. Nose		
10. Throat		
11. Head		
12. Abdomen		
13. Genitalia		
14. Heart		
15. Chest and Lungs		

Orthopedic evaluation

	Normal	Abnormal
16. Neck		
17. Shoulder		
18. Elbow		
19. Wrist and Hand		
20. Spine		
21. Hip		
22. Knee		
23. Lower Leg		
24. Ankle and Foot		

Comments (please describe any abnormalities found and identify by number before comment):

Medical provider's Statement:

Athlete is released for full sport participation at Lakeland College. **Yes:** _____ **No:** _____
Athlete is not released for full participation until the following exams are completed (explain):

Medical provider's signature: _____ **Date:** _____

Medical provider's address: _____

Medical provider's phone number: _____

Athlete's Statement:

I understand that this physical is for no other purpose than to clear me for athletic participation at Lakeland College. I understand it is not a physical for illnesses that may develop in the future. I agree that the information that I have provided on this physical and medical history form are complete and accurate.

Athlete's signature: _____ **Date:** _____

**Lakeland College Athletics
Waiver Form Date**

(please complete all three sections of this form)

**Lakeland College Athletics
Consent for Medical Treatment**

I (**Athlete's Name**): _____ hereby give authorization to undergo medical treatment for any injury or illness that I may sustain or acquire while engaged in collegiate athletics at Lakeland College. I understand that the medical personnel of Lakeland College, including Certified Athletic Trainers and team Physicians, will evaluate and treat any injuries that occur during my athletic participation at Lakeland College within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. (This includes immediate first aid and treatment, X-ray, physician follow-up care, and rehabilitation). I understand that if I sustain a potentially life threatening injury or illness, and in the event that a guardian is unable to be contacted within a reasonable period of time; I authorize any duly qualified medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I understand, the Team Physician and Certified Athletic Trainer have the authority to eliminate me from further participation, in collegiate athletics at Lakeland College, because of an injury and/or because of any undue risk to myself or Lakeland College.

Athlete's Signature: _____ **Date:** _____

Signature of Parent or Legal Guardian: _____ **Date:** _____
(If athlete is under the age of 18)

Assumptions of Risk

I (**Athlete's Name**): _____ realize that participation in athletic activity involves the potential for injury, which is inherent in sports. I acknowledge that even with the best coaching, use of the most advance protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or death.

Athlete's Signature: _____ **Date:** _____

Signature of Parent or Legal Guardian: _____ **Date:** _____
(If athlete is under the age of 18)

Consent to Release Medical Information

I (**Athlete's Name**): _____ give consent to Head Athletic Trainer to release medical conditions, records, and information to staff at Lakeland College. I also understand that in the event that the information puts me or any other at risk (ex MRSA, TB, etc) that Head Athletic Trainer at Lakeland College has my permission to release this information to other athletic staff, health center staff, residence life staff, and janitorial staff members.

Athlete's Signature: _____ **Date:** _____

Signature of Parent or Legal Guardian: _____ **Date:** _____
(If athlete is under the age of 18)

Acknowledgement of Insurance Requirements – If under Parents

I, _____, as parent, guardian or legal representative, attest that
(Parent's name, please print)

_____ has **insurance coverage of no less than \$90,000** under a current,
(Student-athlete's name)

in force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics.

If there is a material change in coverage or expiration of coverage, I agree to notify Lakeland College of this development and update the insurance information I have on file with Lakeland College.

I understand and agree that Lakeland College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Lakeland College.

(Signature)

(Date)

If student is covered under parents' insurance, please MAKE a COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD and ATTACH below.

Front of card (here)

Back of card (here)

THIS FORM MUST BE SIGNED AND RETURNED TO THE LAKELAND COLLEGE ATHLETIC TRAINING DEPARTMENT BY JULY 30, 2012.

Return to:

Lakeland College
Attn: Athletic Training/Sports Medicine
P.O. Box 359 Sheboygan, WI 53082

Acknowledgement of Insurance Requirements – Student

I, _____ attest that I have *insurance coverage of no less than \$90,000*
(Student-athlete's name, please print)

under current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics.

If there is a material change in coverage or expiration of coverage, I agree to notify Lakeland College of this development and update the insurance information I have on file with Lakeland College.

I understand and agree that Lakeland College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Lakeland College.

(Signature)

(Date)

If student has own insurance, please MAKE a COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD and ATTACH below.

Front of card (here)

Back of card (here)

THIS FORM MUST BE SIGNED AND RETURNED TO THE LAKELAND COLLEGE ATHLETIC TRAINING DEPARTMENT BY JULY 30, 2011.

Return to:

Lakeland College
Attn: Athletic Training/Sports Medicine
P.O. Box 359 Sheboygan, WI 53082