

FOR STUDENT-ATHLETES ONLY!

EUREKA COLLEGE Athletic Pre-participation Physical Evaluation

Name _____ Male Female Age _____
Date of Birth ____/____/____ Age _____ Social Security # _____
Parent/Guardian _____ Home Phone _____
Home Address _____ City _____ State _____ Zip _____
Sport(s) _____

Please explain any **YES** answers at the bottom of the page:

	Yes	No
Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a chronic or ongoing illness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a chronic or persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently taking any prescription or non-prescription drugs including an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies? (Insect stings, foods, medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pains during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had shortness of breath after mild exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt dizzy during or immediately following exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of heart disease in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Has your doctor restricted you from sports because of heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had mononucleosis, myocarditis, or other severe viral infections?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have epilepsy or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury in which x-rays were required?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, legs, hands, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had heat exhaustion or heat stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a corrective or support brace during competition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses, contact lenses, or protective eyewear during competition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a dental appliance during competition?	<input type="checkbox"/>	<input type="checkbox"/>
Have a physical ever recommended that you do not participate in contact sports?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever injured: Head Neck Shoulder Elbow Knee Hip Wrist/Hand Ankle/Foot
 Back Forearm Shin Calf

Explain **YES** answers here: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Athlete _____ Date _____

EUREKA COLLEGE Pre-Participation Physical Examination

PHYSICAL EXAM

Name _____ Age _____ Date _____

Height _____ Weight _____ Blood Pressure _____/_____ Heart Rate _____

Vision: Right 20/_____ Left 20/_____ Corrected? Yes No Contacts Glasses

Urinalysis Protein _____ Glucose _____ Blood _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat		
Mouth and Teeth		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Skin		
Genitalia- Hernia (male)		
Musculoskeletal		
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
Neuromuscular		
Physical Maturity (Tanner Stage)		1 2 3 4 5

Further Medical Evaluation

Required: _____

Cleared to Participate Not cleared to participate Date _____ Signature _____