COLORAOD COLLEGE
CAMPUS RECREATION

GENERAL MEDICAL PHYSICAL

Patient's Legal Name: _____

Date of Birth: _____

This form is to be **completed by a physician** prior to the student's participation in the Colorado College's Club Sports program. This form is separate from the Medical History Questionnaire and Pre-Participation Review that are conducted on campus with the Club Sports Medicine staff prior to the athletic season.

Examination		
Height: ☐Transgender	Weight: ☐Other	Gender: ☐ M ☐F
BP:	Pulse:	Temp:
Vision: R 20/	L 20/	Corrected: Y N
Diagnosis of ADD/ADHD/LD: ☐Y	☐N	
Medical	**Normal**	**Abnormal Findings**
Appearance • Marfan's stigmata, kyphoscoliosis, high arches palate, pectus excavutum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency, etc.		
Eyes/Ears/Throat • Pupils equal, no hearing impairments, etc.		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- valsalva)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males)/ Breasts (females)		
Skin • HSV lesions suggestive of MRSA, tinea corporis, etc.		
Neurologic		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck walk, single leg hop		

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Upon examination, the aforementioned patient is:

- ☐ Cleared for all athletic participation without restriction.
- ☐ Cleared for all athletic participation with recommendations for further evaluation or treatment for

  _____

  _____.
- ☐ Not Cleared
  - ☐ Pending Further Evaluation
  - ☐ For Any Sports
  - ☐ For Certain Sports
    - Reason_____

      _____.

Recommendation(s):_____

_____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the general medical physical. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to Colorado College at the request of the patient. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and the parents/guardians).

Name of Physician _____
Date_____

Address_____
Phone_____

Signature of Physician _____
MD or DO

*This form is adapted from the 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Physical Examination Form

Student Name:_____ DOB:____/____/_____ Gender: M F Student ID#_____
Last First MI MO Day Year (circle one)

Address:_____ Phone #: ( )____-_____ Today's Date:____/____/_____
Street City State Zip MO Day Year

Parent/Guardian/Spouse Name:_____ Primary Care Physician:_____
Last First MI

HISTORY

This section is to be carefully completed by the student or his/her parent(s) or legal guardian before participation in Club Sports in order to help detect possible risks. Please utilize the back of this form to explain any 'Yes' answers.

1. Have you had a medical illness/injury since your last checkup or sports physical?	Y / N	11. Have you ever become ill from exercising in the heat?	Y / N
2. Have you ever been hospitalized overnight?	Y / N	Do you cough, wheeze, or have trouble breathing during or after activity?	Y / N
3. Have you ever had surgery?	Y / N	Do you have asthma?	Y / N
4. Are you currently taking ANY prescription or over-the-counter medications, pills, or inhalers?	Y / N	Do you have seasonal allergies that require medical treatment?	Y / N
5. Have you ever taken any supplements or vitamins to help you gain /lose weight or to improve performance?	Y / N	12. Do you have any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee grace, special neck roll, foot orthotics, retainer, hearing aid, etc.)?	Y / N
6. Do you think you are in good health?	Y / N	13. Have you had any problems with your eyes or vision?	Y / N
7. Have you ever had a rash or hives develop during or after exercise?	Y / N	Do you wear glasses, contacts, or protective eyewear?	Y / N
Have you ever been dizzy or passed out during or after exercise?	Y / N	14. Have you ever had a sprain, strain or swelling after an injury?	Y / N
Have you ever had chest pain during or after exercise?	Y / N	Have you ever broken or fractured any bones or dislocated any joints?	Y / N
Do you get tired more quickly than your friends during exercise?	Y / N	Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, **circle** the appropriate and explain on back of this sheet.	Y / N
Have you ever had racing of your heart or skipped heartbeats?	Y / N	Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Finger(s) Hip Thigh Knee Shin/Calf Ankle Foot	
Have you ever had high blood pressure or high cholesterol?	Y / N		
Have you ever been told you have a heart murmur?	Y / N	15. Do you want to weigh MORE or LESS than you do now?	Y / N
Has any family member or relative died of heart problems or of sudden death before age 50?	Y / N	Do you lose weight regularly to meet weight requirements for your sport?	Y / N
Is there a family history of heart problems in a close relative younger than 50 (enlarged heart, cardiomyopathy, electrical conduction problem, abnormal EKG or abnormal heart rhythm)?	Y / N	16. Do you feel stressed out?	Y / N
Have you ever had a severe heart infection (myocarditis, peridcarditis)?	Y / N	17. Record the dates of your most recent immunizations (shots) for: Tetanus_____ MMR _____ Hepatitis B_____ Chickenpox _____	
Is there a family history of Marfan's Syndrome?	Y / N	**FOR FEMALES ONLY**	
Has a physician ever denied or restricted your participation in sports for any heart problem?	Y / N	18. When was your first menstrual period (age)? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another period? _____ How many periods have you had in the last 12 months? _____ What was the longest time between periods in the last year?_____	
8. Have you ever had a severe viral infection within the last month (e.g. mononucleosis)?	Y / N		
9. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungal infections, or blisters)?	Y / N		
10. Have you EVER had a head injury or concussion?	Y / N		
Have you ever been knocked out, become unconscious or lost your memory?	Y / N		
Have you ever had a seizure?	Y / N	Please list any allergies (medications, pollen, food,insects, etc.):	
Do you have frequent or severe headaches?	Y / N	Please list any medical conditions:	
Have ever had numbness or tingling in your arms, hands, legs, or feet?	Y / N	Please list all current medications (include name, dosage, and how often you take it):	
Have you ever had a stinger, burner, or pinched nerve?	Y / N		