OLIVET COLLEGE ATHLETIC TRAINING
PRE-PARTICIPATION PHYSICAL EXAMINATION
(AT FORM #1- 2016-2017)

DOB: _____

Name: _____ SS#: _____ Date: _____

Height:	Weight:	Vision: With correction Without correction	Pulse:	BP:

Orthopedic Examination

Body Part/Joint	Status	Details
Cervical Spine		
Thoracic Spine		
Lumbar Spine		
Shoulder		
Elbow		
Wrist		
Hand/Fingers		
Hip/Pelvis		
Knee		
Ankle		
Foot/Toes		
General Flexibility		

General Examination

Body Part	Status	Details
Head		
Eyes		
Ears		
Nose		
Throat		
Chest		
Heart		
Lungs		
Abdomen		
Skin		
Hernia		

Physician comments and/or recommendations: _____

_____

_____

Athlete cleared to fully participate in athletic activity? **YES** **NO**

If NO, please explain:

_____

_____

Physician Signature _____ Date: _____

Athletic Trainer Signature _____ Date: _____

OLIVET COLLEGE ATHLETIC TRAINING
PRE-PARTICPATION HEALTH HISTORY FORM
(AT FORM #3 -2016-2017)

Name _____ Age_____ SS#_____

Gender: M or F Date of Birth _____ Yr./School_____ Sport(s)_____

Local Address _____ Cell Phone (___)_____

MEDICAL HISTORY

1. Yes No Are you currently taking any medication(s)? If yes, please list _____
_____

2. Yes No Are you currently taking any nutritional, performance, or herbal supplement(s)? If yes, please list. _____

3. Yes No Do you have any known allergies? If yes please indicate below.
__ Medications, please list _____
__ Bees, what medication do you take? _____
__ Food, please list _____
__ Seasonal, what medication do you take? _____

4. Yes No Do you have asthma? If yes, please list medication. _____

5. Yes No Have you ever experienced fainting, dizziness, headaches, or shortness of breath? If yes, please indicate cause(s).
__ Heart __ Physical Exertion __ Heat __ Dehydration __ Unknown
__ Other, please explain. _____

6. Yes No Have you ever been diagnosed with a heart related condition? If yes, please explain.
_____

7. Yes No Has anyone in your family ever died suddenly from a heart or lung condition? If yes, please explain. _____

8. Yes No Have you ever injured (broken/sprained/strained) any part of your body requiring medical attention? If yes, please specify.

SIDE	BODY PART	TYPE OF INJURY	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Yes No Did any of these injuries require surgery? If yes, please specify._____

10. Yes No Have you ever sustained a head injury or concussion? If yes, please specify how many and the year(s) they occurred. _____

11. Yes No Have you ever lost consciousness or blacked or after sustaining a head injury? If yes, how many times and when? _____

12. Yes No Have you ever had a stinger/burner/numbness of the neck/shoulder region? If yes, please specify how many and the year(s) they occurred. _____

13. Yes No Do you utilize any type of assistive devices (braces/orthotics) while participating in athletics? If yes, please specify. _____

14. Yes No Have you ever experienced removal or loss of function of a paired organ? If yes, please specify organ(s)._____

15. Yes No Have you ever been advised that you carry the Sickle Cell Trait/I have Sickle Cell Anemia? _____

****I attest that the above medical history questions have been answered honestly and accurately. ****

Student-Athlete Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____
(Required if under 18 years of age)