



MANDATORY ATHLETIC PRE-PARTICIPATION PHYSICAL FORM

Name: _____ Academic Year: _____

Classification: *(please circle)* **1st year athlete** **2nd year athlete**

Sport: *(please circle all that apply)*

Men's Soccer	Women's Soccer
Volleyball	Women's Basketball
Men's Basketball	Baseball
Softball	Golf
Bowling	

(Physician use only below this line)

Cleared without restrictions

Cleared, with recommendations for further evaluation or treatment for:

Recommendations: _____

Not cleared:

Reason: _____

Allergies: _____

Physician Name: (print) _____ (circle one) MD / DO

Physician Signature: _____ Date: _____

Examination Form

Name: _____

Height: _____ Weight: _____ Pulse: _____ BP: _____/_____

Vision: R 20/ _____ L 20/ _____ Corrected: YES NO Pupils: Equal Unequal

	NORMAL	ABNORMAL FINDINGS/RECOMMENDATIONS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			

	NORMAL	ABNORMAL FINDINGS/RECOMMENDATIONS	INITIALS
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

History Form

Name: _____ Sex: _____ Age: _____ D.O.B.: ____/____/____
month / day / year

“Yes” answers require explanations below.
 Circle questions that you do not know the answer to.

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had a severe viral infection (like mononucleosis or myocarditis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure | | | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | | | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart murmur | | | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart infection | | | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example, EKG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you ever had a skin infection (Staph) requiring antibiotics? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 44. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 45. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 47. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

48. Have you ever had a menstrual period? YES NO

49. How old were you when you had your first menstrual period? _____

50. How many periods have you had in the past 12 months? _____

51. Explain “YES” answers here: _____

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

- | | | |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

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

This document is mandatory for all individuals wishing to participate in intercollegiate athletics at Corning Community College.

All sections must be filled out properly and must have a medical professional's signature to be valid.

This completed document must be provided to the CCC Athletic Trainer prior to participating in any CCC athletically sponsored practice/try-out/exhibition/game.

Please return this form to:

**CCC Athletics – Athletic Trainer
1 Academic Drive
Corning, NY 14830**

or

Submit this document in person to the athletic trainer, coach or athletic office on campus.

Questions:

**Jackie McAtee - CCC Athletic Trainer
607-962-9318 or jmcaatee@corning-cc.edu**