Dear Physician:

Please complete in full the pre-participation history and physical. Be aware NCAA level sports require a high level of physical involvement both in training activities and competitive play. Please evaluate and explain all significant medical history in detail before allowing the athlete to participate.

- Describe the history and physical findings, evaluations, treatments, management and follow-up care of their medical history and physical findings.

Include additional sports clearance from specialists as required and indicated;
- i.e. shoulder, knee, back injury or surgery - requires orthopedist evaluation & clearance
- i.e. heart murmur, arrhythmia, syncope - requires cardiac evaluation & clearance
- i.e. concussions, seizure disorder – requires neurologist evaluation & clearance
  - Include:
    - diagnosis and summary of evaluation, treatment, management, follow-up care, limitation, restrictions if any and clearance to participate in a NCAA level sport.

When considering clearance the athlete’s medical condition and functional abilities, and the demands of the sport, need to be taken into consideration.
ATHLETIC PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

STUDENT-ATHLETE INSTRUCTIONS

Dear Student-Athlete:

The NCAA requires a comprehensive ATHLETIC PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION no more than 6 months prior for participation.

Please complete the attached forms and return them to the athletic office no later than July 1 for the fall semester.

It is important for all athletes to be able to participate at the first scheduled practice. Without the appropriate completed forms on file and full clearance from the College of Saint Elizabeth athletic director, you will not be allowed to participate in practice or competition. Only College of Saint Elizabeth original forms will be accepted.

Information about Athletic Injuries

Whenever a student is injured in a particular sport and requires a physician’s note, she shall not be permitted to practice or take part in athletics until she has received a release from the attending physician. This release must be placed on file in the Health Office and in the Athletic Director’s Office. The athletic trainer/athletic director must be notified of any injuries within 24 hours of the injury.
COLLEGE OF SAINT ELIZABETH
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE—Completed by the physician and student

Part B: PHYSICAL EVALUATION FORM—Completed by the physician

Part A: HEALTH HISTORY QUESTIONNAIRE

Today’s Date: _____________________ Student’s Name: ___________________________________________ Sex: M  F (circle one)
Age: _______ Date of Birth: ___/___/_______ Home Phone: (_____) _______________ Cell Phone: (____) ______________________________
Sport(s): _____________________________________________________________________
Physician Name/ Address ________________________________________________________________________________________________
Physician Phone:  ______________________________ Fax _______________________________

Directions: Please answer the following questions about the student’s medical history by CIRCLING the correct response.

Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had or do you currently have:
   a. Restriction from sports for a health related problem? Y / N / Don’t Know
   b. An injury or illness since your last exam? Y / N / Don’t Know
   c. Have you ever passed out or nearly passed out during/after exercise? Y / N / Don’t Know
   d. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don’t Know
      (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don’t Know
   e. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don’t Know
   f. Have you ever taken steroid pills, steroid injections, or supplements to improve your performance? Y / N / Don’t Know
   g. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don’t Know
   h. Any allergies to medications? Y / N / Don’t Know
   i. Any allergies to bee stings, pollen, latex or foods? Y / N / Don’t Know
      (1.) If yes, check type of reaction:
         □ Rash  □ Hives  □ Breathing or other anaphylactic reaction
      (2.) Take any medication/Epipen taken for allergy symptoms? (List below) Y / N / Don’t Know
   j. Any anemia’s, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don’t Know
   k. A blood relative who died before age 50? Y / N / Don’t Know
   l. Any illicit drugs, alcohol, tobacco usage? Y / N / Don’t Know

Explain all “yes” answers here; include course, treatment, diagnosis, rehab, resolution & dates:
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
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List all medications here:
Medication Name Dosage Frequency (Prescription and non-prescription include supplements, vitamins and performance enhancers)
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
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____________________________________________________________________
____________________________________________________________________
Student's Name: _____________________________________ Date of Birth: ______________

2. Have you ever had, or do you currently have, any of the following head-related conditions:
   a. Concussion or head injury (including “bell rung” or a “ding”)? Y / N / Don't Know
   b. Memory loss? Y / N / Don't Know
   c. Knocked out? Y / N / Don't Know
   d. A seizure? Y / N / Don't Know
   e. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
   f. Fuzzy or blurry vision Y / N / Don't Know
   g. Sensitivity to light/noise Y / N / Don't Know
   h. Headaches with exercise Y / N / Don't Know

Explain all "yes" answers here; include course, treatment, diagnosis, rehab, resolution & dates:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

3. Have you ever had, or do you currently have, any of the following heart-related conditions:
   a. Restriction from sports for heart problems? Y / N / Don't Know
   b. Chest pain or discomfort? Y / N / Don't Know
   c. Heart murmur? Y / N / Don't Know
   d. High blood pressure? Y / N / Don't Know
   e. Elevated cholesterol level? Y / N / Don't Know
   f. Heart infection? Y / N / Don't Know
   g. Dizziness or passing out during or after exercise without known cause? Y / N / Don't Know
   h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? Y / N / Don't Know
   i. Racing or skipped heartbeats? Y / N / Don't Know
   j. Unexplained difficulty breathing or fatigue during exercise? Y / N / Don't Know
   k. Any family member (blood relative):
      (1.) Under age 50 with a heart condition? Y / N / Don't Know
      (2.) With Marfan Syndrome? Y / N / Don't Know
      (3.) With a heart murmur? Y / N / Don't Know
      (3.) Died of a heart problem before age 50? If yes, at what age? ________________
      (4.) Died with no known reason? Y / N / Don't Know
      (5.) Died while exercising? If yes, was it during or after? (Circle one.) Y / N / Don't Know

Explain all “yes” answers here; include course, treatment, diagnosis, rehab, resolution & dates:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Student’s Name: _________________________________________ Date of Birth: _________________

4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth or throat conditions:
   a. Vision problems?
      (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.)
      Y / N / Don’t Know
      Y / N / Don’t Know
   b. Hearing loss or problems?
      (1.) Wear hearing aides or implants?
      Y / N / Don’t Know
      Y / N / Don’t Know
   c. Nasal fractures or frequent nose bleeds?
      Y / N / Don’t Know
   d. Wear braces, retainer or protective mouth gear?
      Y / N / Don’t Know
   e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?
      Y / N / Don’t Know

Explain all “yes” answers here; include course, treatment, diagnosis, rehab, resolution & dates:
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:
   a. Numbness, a “burner”, “stinger” or pinched nerve?
      Y / N / Don’t Know
   b. A sprain?
      Y / N / Don’t Know
   c. A strain?
      Y / N / Don’t Know
   d. Swelling or pain in muscles, tendons, bones or joints?
      Y / N / Don’t Know
   e. Dislocated joint(s)?
      Y / N / Don’t Know
   f. Upper or lower back pain?
      Y / N / Don’t Know
   g. Fracture(s), stress fracture(s), or broken bone(s)?
      Y / N / Don’t Know
   h. Do you wear any protective braces or equipment?
      Y / N / Don’t Know
   i. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injection, rehabilitation, physical therapy, brace, cast, or crutches?
      Y / N / Don’t Know

Explain all “yes” answers here; include course, treatment, diagnosis, rehab, resolution & dates:
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
6. Have you ever had or do you currently have any of the following general or exercise related conditions:

a. Difficulty breathing?
   (1.) During exercise? Y / N / Don’t Know
   (2.) After running one mile? Y / N / Don’t Know
   (3.) Coughing, wheezing or shortness of breathe in weather changes? Y / N / Don’t Know
   (4.) Exercise-induced asthma?
      i. Controlled with medication? (specify __________________________) Y / N / Don’t Know
      ii. Experience dizziness, passing out or fainting? Y / N / Don’t Know

b. Viral infections (e.g. mono, hepatitis, Coxsackie virus)? Y / N / Don’t Know

c. Become tired more quickly than others? Y / N / Don’t Know

d. Any of the following skin conditions:
   (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don’t Know
   (2.) Sun sensitivity? Y / N / Don’t Know

e. Weight gain/loss (of 10 pounds or more)?
   (1.) Do you want to weigh more or less than you do now? Y / N / Don’t Know

f. Eating disorders? Y / N / Don’t Know

g. Ever had feelings of depression? Y / N / Don’t Know

h. Heat-related problems (dehydration, dizziness, fatigue, headache)?
   (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don’t Know
   (2.) Heat stroke (hot, red, dry skin)? Y / N / Don’t Know
   (3.) Muscle cramps? Y / N / Don’t Know

   i. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don’t Know

Explain all "yes" answers here; include course, treatment, diagnosis, rehab, resolution & dates:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Age of onset of menstruation: ______ How many menstrual periods in the last twelve (12) months? ______
How many periods missed in the last twelve (12) months? ______

STUDENT SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

________________________________________       ______________________________________________________
Signature of Student                             Date
Parent/Guardian for Student under 18 years old  Date

PHYSICIAN SIGNATURE

I have reviewed and documented significant information to the athlete’s history.

________________________________________       ______________________________________________________
Physician Name (please print)                   Date
Physician’s Signature                           Date

7/2013 Adapted from NJ Dept. of Education (Sports Physical – 2010)
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

THE COMPLETED AND SIGNED HEALTH HISTORY MUST BE COMPLETED BY THE PHYSICIAN AT THE TIME OF THE MEDICAL EXAM.

Part B: Physical Evaluation Form (Completed by the physician)

STUDENT INFORMATION

Student’s Name: __________________________________ Sport(s): ________________________________________________________________

Sex: M F (circle one) Age: _______ Date of Birth: ________________________________________________________________

Address: ___________________________________________________________________________________________________________

City/State/Zip: __________________________________________ Home Phone: _____________________________________________________

Parent/Guardian’s Full Name: __________________________________________________________________________________

EXAMINING PHYSICIAN CONTACT INFORMATION

Name: ____________________________________________ Phone: __________________________ Fax: ______________________________

Address: __________________________________________ City/State/Zip: ____________________________________________________________

FINDINGS OF PHYSICAL EVALUATION

Height: _______  Weight: _______  Blood Pressure: _______/_______  Pulse: _____bpm.

Vision: R 20/____ L 20/____  Corrected: Y / N  Contacts: Y / N  Glasses: Y / N

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>NORMAL?</th>
<th>ABNORMAL FINDINGS - COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
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<tr>
<td>Head/Neck</td>
<td></td>
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<tr>
<td>Eyes/Sclera/Pupils</td>
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<td>Ears</td>
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<td>Gross Hearing</td>
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<td>Nose/Mouth/Throat</td>
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<tr>
<td>Lymph Glands</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Heart Rate</td>
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<tr>
<td>Rhythm</td>
<td></td>
<td></td>
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<tr>
<td>If murmur present</td>
<td></td>
<td>Standing makes it:: Louder Softer No Change</td>
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<td></td>
<td></td>
<td>Squatting makes it:: Louder Softer No Change</td>
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<td></td>
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<td>Valsalva makes it:: Louder Softer No Change</td>
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<tr>
<td>Femoral Pulses</td>
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<tr>
<td>Lungs: Auscultation/Percussion</td>
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<tr>
<td>Chest Contour</td>
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<tr>
<td>Skin</td>
<td></td>
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<tr>
<td>Abdomen (liver, spleen, masses)</td>
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<tr>
<td>Assessment of physical maturation or Tanner Scale</td>
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<tr>
<td>Testicular Exam (Males Only)</td>
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<tr>
<td>Neck/Bone/Spine:</td>
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<tr>
<td>Range of Motion</td>
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<tr>
<td>Scoliosis</td>
<td></td>
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<tr>
<td>Upper Extremities: (ROM, Strength, Stability)</td>
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<tr>
<td>Lower Extremities: (ROM, Strength, Stability)</td>
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<tr>
<td>Neurological: Balance &amp; Coordination</td>
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<tr>
<td>Hernia</td>
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<tr>
<td>Evidence of Marfan Syndrome</td>
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</tbody>
</table>

7/2013  Adapted from NJ Dept. of Education (Sports Physical – 2010)  Page 7 of 10
Student’s Name: __________________________ Date of Birth: ________________

LABORATORY TESTS (attach lab copy)
Urine Analysis (required)________________________________________________________
CBC (required)_________________________________________________________________
EKG (required)__________________________________________________________________
Sickle Cell Trait Screening (required)_____________________________________________
Additional Labs as indicated_________________________________________________________________

Last Td or Tdap (m/d/y) ____________________________________________
Most recent immunizations and dates administered____________________________________

Medication (please list all medications used dosage and frequency)

________________________________________________________

General Diagnosis, Observations and Recommendations: please explain all past and present medical history that impacted the student’s past and present participation in sports (example: asthma, back injury, concussions, chest pain, murmurs, dysrhythmias, etc.)

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________
THE HISTORY PREPARED BY THE STUDENT MUST BE REVIEWED BY THE PHYSICIAN AT THE TIME OF THE PHYSICAL EXAMINATION.

Student’s Name: ___________________________________________ Date of Birth: _________________

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

☐ A. Student is cleared for participation in all sports without restriction.

☐ B. Student is withheld clearance for participation in any sport until evaluation / treatment of:

____________________________________________________________________________________

☐ C. Student is cleared for participation in limited types of sports which exclude the following types of sports

Contact: (CHECK ALL THAT APPLY)

___ CONTACT/COLLISION       ___ NON-CONTACT/STRENUOUS

___ LIMITED CONTACT         ___ NON-CONTACT/NON-STRENUOUS

Due to: ____________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician’s/Provider’s Stamp:

Physician____________________________________________Date of Exam____________

PHYSICIAN’S SIGNATURE: ___________________________________________ Today’s Date: ______________

HISTORY REVIEWED BY:

Name _______________________________________________ Today’s Date: _____________

SIGNATURE: ___________________________________________ Review Date: ______________

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

- Anaphylaxis;
- Atlantoaxial instability;
- Bleeding disorder;
- Hypertension;
- Congenital heart disease;
- Dysrhythmia;
- Mitral valve prolapse;
- Heart murmur;
- Cerebral palsy;
- Diabetes mellitus;
- Eating disorders;
- Heat illness history;
- One-kidney athletes;
- Hepatomegaly;
- Splenomegaly;
- Malignancy;
- Seizure Disorder;
- Marfan Syndrome;
- History of repeated concussion;
- Organ transplant recipient;
- Cystic fibrosis;
- Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited contact</th>
<th>Non-Contact</th>
<th>Non-strenuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basketball</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
</tr>
<tr>
<td>Diving</td>
<td>Cheerleading</td>
<td>Javelin</td>
<td>Golf</td>
</tr>
<tr>
<td>Field Hockey</td>
<td>Fencing</td>
<td>Shot put</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>High Jump</td>
<td>Rowing</td>
<td></td>
</tr>
<tr>
<td>Ice hockey</td>
<td>Pole Vault</td>
<td>Running/Cross Country</td>
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<tr>
<td>Lacrosse</td>
<td>Gymnastics</td>
<td>Strength Training</td>
<td></td>
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<tr>
<td>Soccer</td>
<td>Skiing</td>
<td>Swimming</td>
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<tr>
<td>Wrestling</td>
<td>Softball</td>
<td>Tennis</td>
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<tr>
<td>Volleyball</td>
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<td>Track</td>
<td></td>
</tr>
</tbody>
</table>

Effects of physiologic maneuvers on heart sounds:

**Standing**
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

**Squatting**
- Increases murmur of AS, MR, AI
- Decreases murmur of MCH
- MVP click delayed

**Valsalva**
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

Physical Stigmata of Marfan's Syndrome

- Kyphosis
- High arched palate
- Pectus excavatum
- Arachnodactyly
- Arm span > height 1.05:1 or greater
- Mitral Valve Prolapse
- Aortic Insufficiency
- Myopia
- Lenticular dislocation

HCM = Hypertrophic Cardiac Myopathy
AS = Aortic Stenosis
AI = Aortic Insufficiency
MR = Mitral Regurgitation
MVP = Mitral Valve Prolapse