LABETTE COMMUNITY COLLEGE
PRE-PARTICIPATION PHYSICAL EXAMINATION

HISTORY

Date of Exam ____________________

Name ____________________ Sex ______ Age ______ Date of birth __________

Class ______ School ______________ Sport(s) ____________________

Address ____

Personal physician ____

In case of emergency, contact

Name ______________ **Relationship** ________ **Phone(H)** ________ **(W)** ________

Explain "Yes" answers below.

Circle questions you don't know the answer to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before the age of 50?	☐	☐
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems, (for example, itching,	☐	☐

rashes, acne, warts, fungus, or blisters)? ☐ ☐

7. Have you ever had a head injury or concussion? ☐ ☐
   Have you ever been knocked out, become unconscious, or lost your memory? ☐ ☐
   Have you ever had a seizure? ☐ ☐
   Do you have frequent or severe headaches? ☐ ☐
   Have you ever had numbness or tingling in your arms, hands, legs, or feet? ☐ ☐
   Have you ever had a stinger, burner, or pinched nerve? ☐ ☐
8. Have you ever become ill from exercising in the heat? ☐ ☐
9. Do you cough, wheeze, or have trouble breathing during or after exercise ☐ ☐
   Do you have asthma? ☐ ☐
   Do you have seasonal allergies that require medical treatment? ☐ ☐
10. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid? ☐ ☐
11. Have you had any problems with your eyes or vision? ☐ ☐
    Do you wear glasses, contacts, or protective eyewear? ☐ ☐
12. Have you ever had a sprain, strain, or swelling after injury? ☐ ☐
    Have you broken or fractured any bones or dislocated any joints? ☐ ☐
    Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? ☐ ☐

If YES, check appropriate box and explain below.

☐Head	☐Elbow	☐Hip	☐Neck	☐Forearm	☐Upper arm
☐Thigh	☐Back	☐Wrist	☐Knee	☐Chest	☐Foot
☐Hand	☐Shin/calf	☐Shoulder	☐Finger	☐Ankle	

13. Do you want to weigh more or less than you do right now? ☐ ☐
    Do you lose weight regularly to meet weight? ☐ ☐
    Requirements for sport? ☐ ☐
14. Do you feel stressed out? ☐ ☐
15. Record the dates of your most recent immunizations (shots) for:

Tetanus_______ Measles_______ Hepatitis B_______ Chickenpox_______

FEMALES ONLY

16. When was your first menstrual period?________________________________
    When was your most recent menstrual period?________________________________
    How much time between the start of one period to the start of another? ________________
    What was the longest time between periods in the last year?________________________
    Explain all "Yes" answers here:____
    ____

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

Signature of athlete________________________ Signature of parent/guardian______________

PHYSICAL EXAMINATION

Name ______________________ Date of birth ______________________

Height ____ Weight ____ % Body fat ____ Pulse ____ BP (___/___, ___/___)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____

	NORMAL	ABNORMAL FINDINGS	Initials
MEDICAL			
Appearance			
Eye/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

____

☐ Not cleared for: ______________________ Reason: ______________________

Recommendations: ____

____

Name of physician (print/type) ______________________ Date ____________

Address ____

Signature of physician ______________________, MD or DO