SPORTS QUALIFYING MEDICAL EVALUATION

Please return this form to: University of Northwestern – St. Paul, Athletic Office
3003 Snelling Avenue N., St Paul MN 55113-1598

Student Name _____
Address _____
Date of Birth _____ Age: _____

Northwestern ID# (If known): _____ ❑ Male ❑ Female
Sport: _____

ATHLETE PLEASE COMPLETE PRIOR TO PHYSICIAN'S EXAM

HISTORY	YES	NO
1. Have you ever fainted?	❑	❑
During exercise?	❑	❑
Have you had chest pain during exercise?	❑	❑
2. Family history of sudden death? Before age 35? _____ Before age 50? ____ Cause _____	❑	❑
3. Have you ever had a concussion, loss of consciousness, or head injury? If yes, how many: _____ When: _____	❑	❑
4. Have you ever had heat stroke or heat exhaustion?	❑	❑
5. Do you wheeze or cough during or after exercise?	❑	❑
Do you have any history of Asthma?	❑	❑
Unexplained shortness of breath?	❑	❑
6. Do you have any allergies? (medications, bee sting pollens, foods): _____	❑	❑
7. Have you been ill in the last month?	❑	❑
8. Do you take any medication? (include vitamins and nonprescription drugs): _____	❑	❑
9. Explain any of the following: Have you ever been hospitalized? If yes, explain: _____	❑	❑
Have you ever had surgery? If yes, explain: _____	❑	❑
Have you ever had a serious accident or injury? Explain _____	❑	❑

10. If female, last menstrual period: _____
Age at onset of first period: _____
Usual cycle. Every _____ days.

11. In last year, what was your
Lowest weight? _____ Highest weight? _____
What do you think is your ideal weight? _____

12. Have you had an eating disorder? (past or present)	❑	❑

13. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia
Broken bones/Stress fracture	Diabetes
Dislocation (shoulder, etc.)	Hearing impairment
Heart murmur/palpitations/arrhytmias	Hepatitis/jaundice
Other heart anomalies	Loss of eye sight
High blood pressure	Scoliosis
Rheumatic fever	Sickle-cell disease
Seizures	Undescended testicle
Single organs (kidney, eye, testicle, etc.)	Blood in Urine

14. Have you had any knee, ankle, or shoulder injuries?	❑	❑
15. Are there any concerns you would like to discuss? (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other)	❑	❑
16. Do you use seat belts on a regular basis?	❑	❑

I do not know of any existing physical condition or additional health reason that would preclude my participation in sports. I certify that the answers to the above questions are true and accurate.

Athlete's Signature _____ Date _____

EXAMINATION **DATE OF EXAM**_____

TO BE COMPLETED BY PHYSICIAN (within 6 months prior to participation)

			YES	NO
HT _____	WT _____	Glasses	❑	❑
Vision	R _____ L _____	Contact Lenses:	❑	❑
Anisocoria	R _____ L _____	Eye Protection	❑	❑

Standing BP _____ Sitting BP _____ Pulse _____

MEDICAL EXAM

	Normal	Abnormal	Comments
HEENT			
Fundoscopic Exam	_____	_____	_____
Ears	_____	_____	_____
Mouth	_____	_____	_____
Throat	_____	_____	_____
Dental	_____	_____	_____
Thyroid	_____	_____	_____
Nodes	_____	_____	_____
Lungs	_____	_____	_____
Cardiac	_____	_____	_____
Including precordial auscultation (supine & standing) and femoral artery pulses.			
Abdomen	_____	_____	_____
Genitalia	_____	_____	_____
Hernia	_____	_____	_____
Skin	_____	_____	_____
Neuro	_____	_____	_____

Labs: UA: _____
Hgb: _____

MUSCULOSKELETAL

	Normal	Abnormal		Normal	Abnormal
Neck	_____	_____	Quad/Hamstring	_____	_____
Shoulder	_____	_____	Ankle/feet	_____	_____
Elbow	_____	_____	Back/Spine	_____	_____
Hands	_____	_____	Toe/Heel Walk	_____	_____
Wrist	_____	_____	Duck Walk	_____	_____

Comments:_____
_____

Date of Last Tetanus Shot _____
*Hepatitis B Vaccine recommended _____

I have reviewed the medical history and herewith certify that _____ (name) has been evaluated in the following areas as indicated below to be physically fit to participate in school interscholastic activities.

Medical History Y/N
Medical Exam Normal/Abnormal
Musculoskeletal Normal/Abnormal

	Cleared for	Not Cleared for
Collision Sports	❑	❑
Contact Sports	❑	❑
Noncontact Sports	❑	❑

Due to: (If not cleared) _____
Modification or exceptions: _____
How long have you been patient's physician? _____
Attending Physicians signature (MD or D0):_____

Print Name: _____

Address _____ Phone #_____
_____

STATEMENT REGARDING ATTENDING PHYSICALS

As a prospective athlete for the University of Northwestern, you will be required to have a complete physical exam by a physician of your choice before you participate in any athletic activities.

The University of Northwestern Athletic Department works hard to maintain strict confidentiality regarding your health information. However, in order for you to perform safely as an athlete, the Athletic Department may need to share the information included on your physical form with Health Services. This includes information concerning current medications, allergies (ex. bee stings), need for corrective lenses, and history of any medical condition or injury that may need to be monitored during your participation in sports. This information may be released to Health Services.

It is because of our strong concern for confidentiality that we want you to be aware of this procedure prior to your physical. Our aim is to help you to safely participate in the University of Northwestern athletic program.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

_____ _____

Signature Date

Printed Name_____

For Northwestern College Health Service Only:

Athletic Clearances					
Date	Sport	Date	Sport	Date	Sport

Please mail this form to:

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3003 Snelling Avenue North
St. Paul, MN 55113